Name: _____ **Date:** _____

Are you on Dialysis? No or Yes – What days? ☐ *Mon/Wed/Friday* ☐ *Tue/Thurs/Sat*

Dialysis Center Name and Address: _____

Dialysis phone #: _____ ***Years on dialysis?*** _____

General Questions

Reason for visit: _____

Females – Are you pregnant? ☐ No or ☐ Yes – Due Date: _____

Do you smoke? ☐ Never ☐ Former Smoker ☐ Yes – Amount per day? _____

Do you drink Alcohol? ☐ No or ☐ Yes – Amount per day? _____

Past Medical History *(ONLY Check ALL that applies to you)*

General

- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ HIV
- ☐ Other: _____

HENT

- ☐ Cataract
- ☐ Glaucoma
- ☐ Headache
- ☐ Hearing loss
- ☐ Hoarseness
- ☐ Sinusitis
- ☐ Sudden Vision loss
- ☐ Vertigo
- ☐ Other: _____

Cardiovascular

- ☐ Angioplasty/Stenting - Heart
- ☐ Congestive heart failure
- ☐ Heart Attack
- ☐ **Heart Disease**
- ☐ Heart Bypass
- ☐ **High Blood pressure**
- ☐ Irregular Heart Rhythm
- ☐ Pulmonary embolism
- ☐ Raynaud's syndrome
- ☐ Other: _____

Respiratory

- ☐ Asthma
- ☐ Bronchitis
- ☐ COPD (Chronic Obstructive Pulmonary Disease)
- ☐ Emphysema
- ☐ Pneumonia
- ☐ Sleep apnea /C PAP
- ☐ Oxygen use
- ☐ Other: _____

Gastrointestinal

- ☐ Pancreatitis
- ☐ Appendicitis/Appendectomy
- ☐ Cholecystitis/ Gallbladder
- ☐ Constipation
- ☐ Gastrointestinal disorder
- ☐ GERD (Reflux Disease)
- ☐ Hiatal Hernia
- ☐ Bowel Obstruction
- ☐ Irritable Bowel Syndrome
- ☐ Hepatitis
- ☐ Ulcer Disease
- ☐ Other: _____

Musculoskeletal

- ☐ Arthritis
  - o Rheumatoid
  - o Osteoarthritis
- ☐ Back Issues
- ☐ Fibromyalgia
- ☐ Gout
- ☐ Osteomyelitis / Bone Infection
- ☐ Osteoporosis
- ☐ Other: _____

Endocrine

- ☐ **Diabetes – Insulin controlled**
- ☐ **Diabetes – Oral Medicine**
- ☐ **Diabetes – Diet controlled**
- ☐ **Hypercholesterolemia**
- ☐ Hyperlipidemia
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Sickle-cell anemia

Neurologic/Psychiatric

- ☐ Alzheimer's disease
- ☐ Anxiety disorder
- ☐ Bipolar disorder
- ☐ Memory loss
- ☐ Migraine
- ☐ Multiple sclerosis
- ☐ Neuropathy
- ☐ Parkinson's disease
- ☐ Seizure disorder
- ☐ **Stroke**
- ☐ **Transient ischemic attack (Mini Stroke)**
- ☐ Other: _____

Skin

- ☐ Cellulitis & Abscess
- ☐ Pressure ulcer
- ☐ Swelling
- ☐ Impetigo
- ☐ Lymphedema
- ☐ Psorarisis

Genitourinary

- ☐ Kidney Failure
- ☐ Bladder Infection
- ☐ Blood in urine
- ☐ Kidney Stone
- ☐ Other: _____

Vascular

- ☐ Abdominal aortic aneurysm
- ☐ Carotid Blockage
- ☐ DVT
- ☐ Leg swelling
- ☐ PAD (legs)
- ☐ Thoracic aneurysm
- ☐ Varicose veins / Spider veins
- ☐ Other: _____

Past Surgical History (Please check all that apply to you)

- ☐ Appendectomy
- ☐ Back Surgery
- ☐ Bowel Obstruction
- ☐ Breast Surgery
  - Type: _____
- ☐ Cataract Surgery
- ☐ Cholecystectomy (Removal of Gallbladder)
- ☐ Colonoscopy
- ☐ Colon - Type: _____
- ☐ C-section
- ☐ Heart Surgery
  - Type:_____
- ☐ Hemorrhoidectomy
- ☐ Hernia Surgery
  - Type: _____
- ☐ Hysterectomy
- ☐ Lung Surgery
  - Type: _____
- ☐ Orthopedic Surgery
  - Type: _____
- ☐ Thyroid Surgery
- ☐ Tubal Ligation
- ☐ Other Surgery: _____

Past Vascular Surgery

- ☐ Carotid Endarterectomy
- ☐ Lower Extremity Bypass
- ☐ Aortic Aneurysm
- ☐ Leg amputation
- ☐ Varicose vein operations
- ☐ Balloon Angioplasty/Stents
- ☐ Other: _____

Family Medical History

	Alive	Deceased - Age	Medical Disorder	
FATHER	☐	☐ Age:	☐ Aortic Aneurysm ☐ Heart Disease ☐ High Cholesterol	☐ Diabetes ☐ High Blood Pressure ☐ Stroke
MOTHER	☐	☐ Age:	☐ Aortic Aneurysm ☐ Heart Disease ☐ High Cholesterol	☐ Diabetes ☐ High Blood Pressure ☐ Stroke
BROTHERS	☐	☐ Age:	☐ Aortic Aneurysm ☐ Heart Disease ☐ High Cholesterol	☐ Diabetes ☐ High Blood Pressure ☐ Stroke
SISTER	☐	☐ Age:	☐ Aortic Aneurysm ☐ Heart Disease ☐ High Cholesterol	☐ Diabetes ☐ High Blood Pressure ☐ Stroke

PATIENT SIGNATURE **DATE**

Patient Name: _____Date:_____

ALLERGIES *CHECK ONLY THOSE YOU ARE ALLERGIC TO*

☐ **No Known Allergies**

- ☐ Adhesive / Tape
- ☐ Aspirin
- ☐ Latex
- ☐ Local Anesthesia
- ☐ Penicillin
- ☐ Codeine
- ☐ Demerol
- ☐ Lortab/Norco
- ☐ Sulfa
- ☐ X-Ray dye
- ☐ Iodine
- ☐ Morphine
- ☐ Other Allergies: _____

Medication List

BLOOD THINNERS that you are currently taking: _____

Please list ALL medications that you are currently taking or provide us with a list to copy:

Name of Medicine (Ex: Lisinopril)	Dosage (Ex: 25mg)	Administration (By mouth (Oral); Injection; IV)	Frequency (How many times a day)

PATIENT SIGNATURE **DATE**