Nephrology P.A. CONSULTANTS
302**4**KIDNEY.com

Patient Referral & Pre-Appointment Questionnaire

Name: ______________________________ Date: ____________________

REFERRING PHYSICIAN INFORMATION

Physician/Providers **Name**: ______________________________
Physician/Providers **Address**: ______________________________
Physician/Providers **Phone #**: ______________________________
Physician/Providers **Fax #** (if known): ______________________________

PRIMARY PHYSICAN INFORMATION

□ Same as above?
Physician/Providers **Name**: ______________________________
Physician/Providers **Address**: ______________________________
Physician/Providers **Phone #**: ______________________________
Physician/Providers **Fax #** (if known): ______________________________
Hospital Last Admitted in (please mark one):
□ Christiana □ Wilmington □ St Francis □ Union □ Kent General

PRE-APPOINTMENT QUESTIONNAIRE

To help us get the most out of today's visit, please answer the following questions.

1. **What is your main purpose in coming to our office today?** (If you have a new complaint, indicate how long it has been present, what it feels like, what makes it better or worse, and what you are concerned the problem might be?)
____
____
____
2. **Do you have any other concerns?** □ Yes (list below) □ No
____
____
3. **Has anything new come up in your family history?** □ Yes (list below) □ No
(For example, have any of your blood relatives recently developed a new illness?)
____
4. **Have you developed any new drug allergies?** □ Yes (list below) □ No
____
5. **What do you do for exercise?** How long?____________________ How often?____________________
6. **How much tobacco do you smoke or chew per day?** ____________________ **Note:** It is recommended that you stop using tobacco. We can enroll you in a tobacco-cessation class.
7. **How much alcohol do you consume per week?** ____________________
8. **How much caffeine do you consume per day?** (ie., coffee, tea, chocolate, soda)
9. **What method of birth control do you use?**
□ Not Applicable □ The Pill □ Vasectomy □ Tubal Ligation □ Other (specify): ____________________

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History Form

Age & Cause of Death if Deceased	Relative		Relative		Relative
____ Alcoholism		____ Glaucoma		____ Migraine	
____ Anemia		____ Hay Fever/Allergies		____ Osteoporosis	
____ Arthritis		____ Heart Disease		____ Seizures/Epilepsy	
____ Asthma		____ High Cholesterol		____ Stroke	
____ Bleeding disorder		____ Hypertension		____ Thyroid Disease	
____ Cancer		____ Kidney Disease			
____ Diabetes		____ Mental Illness			

Personal Medical History			
____ Allergies	____ Chronic Pain	____ Heart Attack/MI	____ Sexual Dysfunction
____ Anemia	____ COPD	____ Heart Palpitations	____ Shortness of Breath
____ Anxiety	____ Diabetes	____ Heart Murmur	____ Stroke/TIA
____ Arrhythmia	____ Dizziness/Fainting	____ High Blood Pressure	____ Ulcers
____ Arthritis	____ Epilepsy	____ Liver Disease	____ Chest Pain/Tightness
____ Asthma	____ Fatigue	____ Menstrual Dysfunction	____ High Cholesterol
____ STD	____ GI Disorder	____ Renal Disease	____ Depression
____ Claudication	____ Abdominal Pain	____ Rheumatic Fever	____ Joint Pain
____ CHF	____ Headache/Migraine	____ Scarlet Fever	____ Wheezing

Other Medical History			
____ Numbness in Hands/Feet	____ Difficulty Hearing	____ Coughing up Blood	____ Diarrhea
____ Leg Pain/Cramps When Walking	____ Excessive Thirst	____ Night Sweats	____ Constipation
____ Painful Sores/Ulcers on Legs/Feet	____ Double Vision	____ Skin Rash	____ Mood Swings
____ Swelling in Legs/Feet/Ankles	____ Frequent Urination	____ Trouble Sleeping	____ Fever
____ Bloody Bowel Movements	____ Black Bowel Movements	____ Weight Loss	
____ Painful Urination	____ Chills	____ Nose Bleeds	
____ Difficulty Swallowing	____ Cough	____ Vomiting	

Social History		
Occupation		Exercise
Seat Belts Y N	Marital Status	Diet
Tobacco Use Y N Packs/Day How many years?	Alcohol Use Y N How Often? Amount Type	Street Drugs Y N How Often? Amount Type

Procedures/Surgeries	Date

Name: ____ Date: __________

Date of Birth: ____/____/_________