

NEW PATIENT MEDICAL INFORMATION

Southwest Atlanta Nephrology
MLK, LITHONIA, EAST POINT, CANDLER, LINDEN

Name: _____

Date: _____

Name of Patient's Primary Care Physician: _____

Age: _____

History of Present Illness: _____

ACTIVE MEDICAL PROBLEMS:	Physician's Comments
1)	
2)	
3)	
4)	

GENITOURINARY COMPLAINTS	Yes	No	Physician's Comments
Pain or Burning			
Frequent Nighttime Urination			
Constant Urge to Urinate			
Difficulty Starting Urine			
Difficulty Stopping Urine			
Foamy Urine or protein in urine			
Frequent bladder/kidney infection			
Blood in urine			
Leaking urine			
History of kidney stones			
Swelling of legs			
Itching			
Bad taste in mouth			
Coughing up blood			

YOUR PAST MEDICAL HISTORY: **** Please answer each of the following as it relates to you. ****

ILLNESSES	Yes	No	Physician's Comments
Diabetes			
Has diabetes affected your eye?			
High Blood Pressure			
Heart Disease			
Lung Disease			
Blood Disorders			
History of blood transfusion?			
Liver Disease			
Stroke			
Arthritis			
Cancer			

OTHER ILLNESSES:	Year	Comments						
SURGERIES:	Year	Comments						
IMMUNIZATIONS:	Year	Yes	No		ALLERGIES	Yes	No	Reaction
Hepatitis B					Penicillin			
Pneumovax					Sulfa			
Influenza					Contrast			
Tetanus					Latex			
					Other Meds			

******MEDICATIONS:** List all Prescription medications you are currently taking.

Medicine	Strength	Amount per Day	Comments

**** Please list all **NON-Prescription** medications you take regularly.

MEDICINE	Strength	Amount per Day	Comments

FAMILY MEDICAL HISTORY:

ILLNESSES	Yes	No	If Yes, Who?	Comments
Diabetes				
High Blood Pressure				
Heart Disease				
Kidney Disease				
Arthritis				
Cancer				
Other				

FAMILY HISTORY	Age	State of Health (if Deceased, please state cause of death)
Mother		
Father		
Sisters		
Brothers		
Children		

SOCIAL HISTORY:			
Highest level of Education: _____ Work Status: Full-time Part-Time Retired Disabled Other: _____			
Occupation: _____ Employer: _____ How Long: _____			
Marital Status: Single Married Separated Divorced			

HABITS:	Yes	No	Amount per Day	Began use at what age?
Cigarettes or other tobacco				
Alcohol (specify)				
Drugs (specify)				
Tattoos				

REVIEW OF SYSTEMS: Answer each area as it relates to you, making comments when necessary.

CONSTITUTIONAL SYMPTOMS	Yes	No	Comments
Weakness			
Weight Loss			
Weight Gain			
Night Sweats			
Fever			

EYES	Yes	No	Comments
Blurred Vision			
Other			
Have you had a recent eye exam?			

EARS, NOSE & THROAT	Yes	No	Comments
Nosebleeds			
Other			

RESPIRATORY	Yes	No	Comments
Cough			
Cough up Blood			
Wheezing			
Shortness of breath at rest			
Shortness of breath when walking			
Chest Pain w/cough or breathing			

CARDIOVASCULAR	Yes	No	Comments
Chest Pain/Tightness			
Irregular Heartbeat			
Swelling of Legs/Feet			
Other			

GASTROINTESTINAL	Yes	No	Comments
Vomiting			
Diarrhea			
Abdominal pain			
Black Stools			
Red Blood in Stools			
Other			

MUSCULOSKELETAL	Yes	No	Comments
Painful Joints			
Swelling in Joints			
Deformities of the Joints			
NEUROLOGIC			
	Yes	No	Comments
Headaches			
Loss of Sensation			
PSYCHIATRIC			
	Yes	No	Comments
Depression			
Insomnia			
Nervousness			
BREASTS			
	Yes	No	Comments
Lumps			
Pain			
Discharge			
SKIN			
	Yes	No	Comments
Itching			
Extreme Dryness			
Rash			
OBSTETRICAL			
	Num.	None	Comments
Pregnancies			
Full-term Deliveries			
Number of children over 9 lbs.			
Miscarriages			
Stillbirths			
Complications during pregnancy?	Yes	No	If yes, what kind? High blood pressure / Toxemia / Severe Hemorrhage / Other_____

M.D. Signature

Date