



Instructions for Consultation with Rockford Nephrology Associates

Please fill out the Initial Patient Information Survey.

Items to bring with you to your appointment:

1. Completed Initial Patient Information Survey
2. A current medication list or all pill bottles
3. Insurance card.

Please come prepared to provide a urine sample during your appointment.

Appointment Date:

Appointment Time:

Provider:

Location:

PAST MEDICAL HISTORY

Please mark YES or NO for the following conditions.

CONDITION	CIRCLE ONE	YEAR CONDITION BEGAN	ADDITIONAL DETAILS
Congestive Heart Failure	YES / NO		
Coronary Artery Disease	YES / NO		
Myocardial Infarction	YES / NO		
Diabetes, Type 1	YES / NO		
Diabetes, Type 2	YES / NO		
Cirrhosis	YES / NO		
Gastrointestinal Bleeding	YES / NO		
Cancer	YES / NO		
Hypertension	YES / NO		
Kidney Stones	YES / NO		
Stroke	YES / NO		
Seizure Disorder	YES / NO		
Transient Ischemic Attack	YES / NO		
Diabetic Retinopathy	YES / NO		
Anxiety	YES / NO		
Depression	YES / NO		
Asthma	YES / NO		
Chronic Obstructive Lung Disease	YES / NO		
Sleep Apnea	YES / NO		
Gout	YES / NO		
Peripheral Vascular Disease	YES / NO		

SOCIAL HISTORY

Education

Highest level of education: _____

Occupation

Are you retired? NO / YES *If YES, last job:* _____

Current job: _____ Hours/week: _____

Personal Relations

Marital Status: Single / Married / Separated / Divorced / Widowed

Spouse's Name: _____

Who do you live with? _____

Power of Attorney for Health care

Do you have a power of attorney for health care? NO / YES

If YES, Name: _____ *Relationship:* _____

DNR Decision Date: _____

Alcohol Consumption

Do you drink alcohol: NO / YES *If YES, amount:* _____

Tobacco Use

Do you smoke cigarettes? NO / YES

If YES, how many Packs/Day: _____

Years Smoked: _____

Did you quit smoking cigarettes? NO / YES *If YES, date quit:* _____

Do you smoke cigars? NO / YES

Do you chew tobacco? NO / YES

Recreational Drugs

Do you currently or have you used recreational drugs? NO / YES

If YES, drugs Used: _____

Date quit: _____

FAMILY MEDICAL HISTORY

Please fill out your family medical history below.

Family Member	Alive	Current Age OR Age at Death	Medical Conditions, Cause of Death
Mother	YES / NO		
Father	YES / NO		
Brother / Sister	YES / NO		
Brother / Sister	YES / NO		
Brother / Sister	YES / NO		
Brother / Sister	YES / NO		
	YES / NO		
	YES / NO		
	YES / NO		
	YES / NO		

ALLERGIES

Do you have any allergies to medications? If yes, please indicate the medication name/s and reaction below.

- No medication allergies
- Yes

Medication	Reaction