NORTH CAROLINA NEPHROLOGY, P.A.

1-877-NCN-NCN9 (1-877-626-6269)

NEW PATIENT PROFILE

PATIENT NAME: _____ Date of Birth: _____
First MI Last

Sex: □ Male □ Female □ Undefined Soc Sec #: _____

Preferred Language: _____ Race: _____

Ethnicity: □ Not Hispanic or Latino □ Hispanic or Latino □ Patient Declined

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ (preferred) □ Home □ Mobile □ Work

_____ (alternate) □ Home □ Mobile □ Work

Email: _____

Emergency Contact: _____ Phone #: _____

Emergency Contact Relationship to Patient: _____

Employed: □ Yes □ No Patient's Employer: _____

Employer Address: _____ Work #: _____

Referring Physician: _____

Primary Care: _____

Insurance: Please bring your insurance cards to your visit and complete the information below.

Do you have an insurance that requires Prior Authorization (Veterans, Tricare, HMO, etc)? Please ensure this is obtained prior to your visit. Without it, incurred charges are the patient's responsibility.

Guarantor: _____
Name DOB Relationship to pt

Primary Insurance

_____
Insurance Company ID # Group #

Policy Holder Info if different from patient: _____
Name DOB

Secondary Insurance

_____
Insurance Company ID # Group #

Policy Holder Info if different from patient: _____
Name DOB

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MEDICAL HISTORY
(Confidential)

Patient's Name: _____
First MI Last

Date of Birth: _____ Soc Sec #: _____

What is the reason for your visit? _____

Please √ if you have ever had any of the following. Use the _____ space to provide details and/or year of onset.

KIDNEY DISEASE

□ CKD: □ Stage 1 □ Stage 2 □ Stage 3 □ Stage 4 □ Stage 5 □ Unknown

□ Transplant: Year: _____

Type: □ Cadaveric □ Living Related □ Living Unrelated

□ Dialysis: Year: _____ Type: □ Hemodialysis □ Peritoneal Dialysis

□ Polycystic kidney disease

□ Acute kidney injury Details: _____

□ Glomerulonephritis

DIABETES

□ Diabetes Type 1
□ Diabetes Type 2
□ Diabetes Type Unknown

HIGH BLOOD PRESSURE

□ Essential
□ Renovascular
□ White Coat
□ Conn's Syndrome

ISCHEMIC HEART DISEASE

□ Heart Attack Yr: _____
□ Angina
□ Angioplasty: Yr: _____
□ Coronary Stent Yr: _____
□ CABG Yr: _____

□ **STROKE** Yr: _____

□ **GOUT**

CANCER

□ Lung _____ □ Lymphoma _____
□ Breast _____ □ Kidney _____
□ Prostate _____ □ Thyroid _____
□ Colon _____ □ Leukemia _____
□ Melanoma _____ □ Endometrial _____
□ Bladder _____ □ Pancreatic _____
□ Other: _____

ENT

□ Blindness
□ Cataracts
□ Hearing Problems
□ Glaucoma

CARDIOVASCULAR

□ Atrial fibrillation □ AICD
□ Pacemaker □ Valvular heart disease
□ High cholesterol □ Congestive heart disease
□ Mitral valve prolapse

Patient Name: _____ Date of Birth: _____

MEDICAL HISTORY - CONTINUED
(CONFIDENTIAL)

RESPIRATORY

- □ COPD
- □ Chronic bronchitis
- □ Asthma
- □ Emphysema
- □ Pneumonia
- □ Tuberculosis
- □ Sleep apnea

HEMATOLOGY

- □ Anemia
- □ Sickle cell disease
- □ Sickle cell trait
- □ Blood transfusion
- □ Thalassemia

GASTROINTESTINAL

- □ GERD (gastric reflux)
- □ Stomach/bowel ulcers
- □ Gall bladder disease
- □ Hepatitis
- □ Inflammatory bowel disease
- □ Irritable bowel syndrome
- □ Gluten intolerance
- □ Lactose intolerance

IMMUNO/ALLERGY

- □ HIV
- □ AIDS
- □ Rheumatoid arthritis
- □ Lupus

GENITOURINARY

- □ Enlarged prostate
- □ Kidney stones
- □ Frequent UTIs

OB HISTORY

- □ Preeclampsia
- □ Pregnancy induced hypertension
- □ Gestational diabetes
- □ History of complicated pregnancy

MUSCULOSKELETAL

- □ Osteoarthritis
- □ Osteoporosis

NEUROLOGIC

- □ Multiple sclerosis
- □ Seizures
- □ Parkinson's
- □ Dementia

PSYCHIATRIC

- □ Depression
- □ Anxiety disorder

ENDOCRINE

- □ Hypothyroidism
- □ Hyperthyroidism
- □ Hyperparathyroidism
- □ Adrenal insufficiency

SURGICAL HISTORY

- □ Appendectomy Year: _____
- □ CABG Year: _____
- □ Carotid endarterectomy Year: _____
- □ Cataract surgery Year: _____
- □ D & C Year: _____
- □ Gall bladder removal Year: _____
- □ Gastric bypass Year: _____
- □ Hemorrhoidectomy Year: _____
- □ Hernia repair Year: _____
- □ Hip replacement Year: _____
  □ Left □ Right □ Bilateral
- □ Knee replacement Year: _____
  □ Left □ Right □ Bilateral
- □ Hysterectomy Year: _____
- □ Prostatectomy Year: _____
- □ Nephrectomy Year: _____
- □ Renal transplant Year: _____
- □ Thyroidectomy Year: _____
- □ Tonsillectomy Year: _____
- □ Valve replacement Year: _____
- □ AV fistula Year: _____
- □ AV graft Year: _____
- □ PD Catheter Year: _____
- □ Other: _____

Patient Name: _____ Date of Birth: _____

FAMILY HISTORY

Do the following family members have any of the following medical conditions?

Kidney Disease	□ Father	□ Mother	□ Sibling	□ Child
Diabetes	□ Father	□ Mother	□ Sibling	□ Child
High Blood Pressure	□ Father	□ Mother	□ Sibling	□ Child
Ischemic Heart Disease	□ Father	□ Mother	□ Sibling	□ Child
Cancer	□ Father	□ Mother	□ Sibling	□ Child
Stroke	□ Father	□ Mother	□ Sibling	□ Child
Gout	□ Father	□ Mother	□ Sibling	□ Child
Adult Polycystic Kidney Disease	□ Father	□ Mother	□ Sibling	□ Child
Dementia	□ Father	□ Mother	□ Sibling	□ Child

FAMILY HISTORY – STATUS

Father: □ Living □ Deceased □ Unknown Age at death: _____ Cause of Death: _____

Mother: □ Living □ Deceased □ Unknown Age at death: _____ Cause of Death: _____

Other Family History not listed above:

_____

_____

_____

Patient Name: _____ Date of Birth: _____

SOCIAL HISTORY

Current Marital Status: □ Married □ Single □ Divorced □ Separated □ Widowed

Living Arrangement: □ Alone □ Spouse □ Significant Other □ Family member

□ In home caregiver □ Assisted living facility

Occupation: □ Retired □ Employed □ Student □ Unemployed

Current/former occupation: _____

Funcational/Cognitive:
□ No impairment
□ Hearing loss
□ Limited mobility
□ Memory deficit
□ Poor vision or blindness
□ Transportation challenges

SOCIAL HISTORY – HABITS

Tobacco use : □ Never used □ Current user □ Former user □ Unknown

□ Cigarettes □ Chewing tobacco □ Pipes □ Snuff □ Cigars

If a former user, what year did you quit? _____

If a current/former smoker, how often do/did you smoke?

□ Every day □ Some days □ Unknown

How many packs per day do/did you smoke? _____ packs per day

How many total years have you smoked? _____ Years

Alcohol Use: □ Never used □ Current user □ Former user

□ Occasional social drink □ 1-2 drinks per day □ 3 or more drinks per day

If a former user, what year did you quit? _____

Recreational Drug Use: □ Never used □ Current user □ Former user: Year quit: _____

□ Marijuana □ Heroin □ Cocaine □ Amphetamines
□ Ectasy □ Barbiturates □ LSD □ Opium
□ Other _____

Other Social History not listed above: _____

_____

_____

Patient Name: _____ Date of Birth: _____

REVIEW OF SYSTEMS

Constitutional

□ Fever
□ Weight gain
□ Weight loss
□ Fatigue
□ Chills
□ Weakness

HEENT

□ Vision impaired
□ Eye pain
□ Redness
□ Color blindness
□ Double vision
□ Hearing loss
□ Ear pain
□ Sinus problems
□ Sore throat
□ Nose bleeds
□ Headache
□ Hoarseness
□ Tinnitus
□ Vertigo

Respiratory

□ Shortness of breath
□ Shortness of breath at rest
□ Shortness of breath with activity
□ Pain with breathing
□ Cough
□ Wheezing
□ Blood in sputum
□ Night sweats

Cardiovascular

□ Chest pain
□ Palpitations
□ Claudication
□ Orthopnea
□ Edema
□ PND

Gastrointestinal

□ Abdominal pain
□ Nausea
□ Diarrhea
□ Heartburn
□ Vomiting
□ Constipation
□ Anorexia
□ Trouble swallowing
□ Indigestion

Genitourinary

□ Urinary urgency
□ Urinary burning or pain
□ Blood in urine
□ Urinary frequency
□ Urinary hesitancy
□ Foamy urine
□ Incontinence
□ Nocturia

Musculoskeletal

□ Back pain
□ Arm weakness
□ Muscle pain
□ Leg weakness
□ Neck pain
□ Joint pain

Skin

□ Rash
□ Itching
□ Scaling
□ Dryness
□ Color change

Neurologic

□ Numbness
□ Tremors
□ Seizures
□ Tingling
□ Fainting

Psychiatric

□ Depression
□ Insomnia
□ Anxiety

Endocrine

□ Heat intolerance
□ Cold intolerance
□ Excessive thirst
□ Excessive urination

Hematology

□ Bleeding gums
□ Easy bruising

Immuno/Allergy

□ Seasonal allergies
□ Hives

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MEDICATION LIST

Please list all medications prescribed by a physician, over-the-counter, and supplements (Examples: Aspirin, vitamins, fish oil, etc).

NAME OF MEDICATION	STRENGTH	DIRECTIONS FOR TAKING THIS MEDICATION	ARE YOU TAKING IT AS DIRECTED Y/N

ALLERGY LIST

NAME OF MEDICATION	REACTION	DATE OF ONSET

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AUTHORIZATION TO DISCLOSE HEALTHCARE INFORMATION

Patient's Name: _____
First MI Last

Date of Birth: _____ Soc Sec #: _____

Authorized Individual/Organizations:

Name: _____ Relationship: _____

Address: _____ Phone: _____

Name: _____ Relationship: _____

Address: _____ Phone: _____

Name: _____ Relationship: _____

Address: _____ Phone: _____

This request and authorization applies to: □ All healthcare information.

□ Healthcare information relating to the following treatment, condition, or dates: _____

_____

Other: _____

Definition: I understand that authorizing the disclosure of this health information is voluntary. I can revoke this authorization at any time. To revoke, I must do so in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the information in my health records may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS) or HIV. It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

_____ _____
Patient Signature Date