Patient Demographic Inforamtion

Last Name: _____ **First Name**: _____ **Middle Initial**: _____
Street Address: _____
City: _____ **State**: _____ **Zip Code**: _____
Home Phone: _____□ Brief Message or □ Extended Message
Cell Phone: _____ □ Brief Message or □ Extended Message
Marital Status: □Single □ Married □ Divorced □ Widowed □ Other
Email:_____ **Will you be using our Patient Portal**□ Yes □ No
Date of Birth: _____ **SS#**_____ **Sex:** □M □F
Race:
□American Indian □ Black or African American □Pacific Islander
□Alaska Native □Hispanic □White □Asian □Native Hawaiian
□Other □Do not wish to report
Ethnicity:
□Hispanic □Latin □Not Hispanic or Latin □Do not wish to report
Primary Language: _____ if not English is a translator needed? □Yes □No
Transportation:
Do you rely on Medical Transport: □ Yes □ No
If yes Company Name_____ Phone Number: _____

Advance Directive: □Yes □No
If yes who is your Healthcare Representative:_____
Emergency Contact
Contact Name: _____**Relationship to Patient**: _____
Home Phone #:_____**Cell Number**: _____
When may we contact this person:_____

Primary & Referring Physician Information
Primary Care Physician: _____
Address: _____ **City**: _____**State:** _____**Zip Code**: _____
Phone: _____ **Fax:** _____

Referring Physician (if different from Primary):_____
Address: _____ **City:** _____ **State:** _____**Zip Code:** _____
Phone: _____ **Fax:** _____

Pharmacy Information

Pharmacy: _____Phone #:_____
Address:_____
Mail Order Pharmacy: _____Phone#: _____
Preferred Pharmacy: □ Local Pharmacy or □ Mail Order

Patient Signature:_____ Date:_____

New Patient Medical Questionnaire

Patient Name: _____
DOB: _____
Appointment Date:_____

Why were you referred to Haddon Renal? What are your signs and symptoms?

_____

_____

Family History
List present health or cause of death of your family members:

Father: _____Mother: _____

Brothers: _____Sisters: _____

Children: _____

Check illnesses which have occurred in any of your blood relatives:

□Anemia □High Blood Pressure
□Bleeding Disorder □ Kidney Disease
□Cancer □ Stroke
□ Diabetes □Heart Disease
□Kidney Stones
□Other_____

_____

Social History

Are you: □Single □Married □Divorced □Widowed

Spouse/Partner Name:_____ Number of Children_____

Who lives with you?_____ □I live alone

□ I live in Assisted Living / Nursing Facility Facility Name:_____

Address:_____ Phone Number:_____

Do you drink alcohol? □ No □Yes Drinks per day:_____ for _____years; Quit in_____

Have you ever smoked? □ No □Yes Packs per day: _____or_____ years: Quit in_____

Do you use marijuana or recreational drugs? □Yes □No

What type?_____ How Often _____ _____

Health Screening

Colonoscopy: □Yes □No Date: _____Doctor:_____

Flu VACCINE: □Yes □No Date: _____Doctor:_____

Chest x-ray: □Yes □No Date: _____ _ Doctor:_____

EKG: □Yes □No Date: _____ Doctor:_____

Cholesterol screening: □Yes □No Date: _____Doctor:_____

HADDON RENAL Medical Specialists

New Patient Medical Questionnaire

Patient Name:_____
DOB: _____

Labs
Primary Lab:_____
Last Labs: Date:_____ Lab:_____
Renal Imaging
Facility:_____ Study Performed:_____
Date:_____

My Medical History
Check all the illnesses or conditions which you have:

□Anemia	□Depression	□Kidney Disease
□Anxiety	□Diabetes	□Nervous Disorder
□Asthma	□Edema	□Pneumonia
□Bleeding Disorder	□Glaucoma	□Prostate Problems
□Cancer	□Hearing Loss	□Protein in Urine
□COPD	□Heart Attack	□Rheumatic Fever
□Congestive Heart Failure	□Heart Disease	□Stroke
□Coronary Artery Disease	□High Blood Pressure	□Tuberculosis
□Complications of Pregnancy	□Jaundice	□Vascular Disease

□Consistent use of Non-Steroidal Aides (NSAIDS): (ex:Motrin, Aleve, Ibuprofen,Naproxen, Indocin, Mobic, Excedrin.)

Surgeries within the last year

List all Surgeries	Date	Hospital

Hospitalizations within the last year

Admission Date	Reason	Discharge Date	Hospital

New Patient Medical Questionnaire

Patient Name:_____
DOB: _____

Medications - List all medications with the dose and frequency including over the counter meds.

Medication Name	Dose	Frequency	Notes

□ Copy of updated list attached

Medications Allergies and type of Reaction:

Medication	Reaction

Patient Signature:_____ Date:_____