Western Nephrology
Caring for People with Kidney Disorders

Office Staff Only:
PI ______________
SI ______________
PFA/PP__________
CP______________
TZ______________

Please Complete the Following Questionnaire

Name: ______________________ **Date of Birth:** __________ **Email Address:** ______________________

Street Address: ______________________ **City:** ______________ **State:** ____ **Zip:** ________

Home Phone: ______________________ **Cell Phone:** ______________________ **PCP:** ______________________

Primary Insurance: ______________________ **Secondary Insurance:** ______________________

Preferred Pharmacy: ______________________ **Referring Provider**: ______________________

Do you have an Advance Directive? (Living will, Power of Attorney, Do Not Resuscitate) ☐ YES ☐ NO

Date of your last blood draw (Month/Year) ______________________ Where? ☐ Western Nephrology ☐ Other

Date of your last Flu Vaccine (Month/Year) ______________________

Have you developed any NEW allergies since your last visit? ☐ YES ☐ NO

If yes, please explain: ____

____

Have you had any surgery since your last visit? ☐ YES ☐ NO

If yes, please explain: ____

____

Have you been hospitalized since your last visit? ☐ YES ☐ NO

If yes, please explain: ____

____

Do you smoke? ☐ YES ☐ NO

Do you drink alcohol? ☐ YES ☐ NO

Do you use recreational drugs? ☐ YES ☐ NO

Any changes in your history since your last visit (e.g. social, medical, or family changes)**?** ☐ YES ☐ NO

Have you experienced any of the following symptoms ***since your hospital visit?***

Do Not Include Chronic Symptoms

	Y	N		Y	N		Y	N
Change in appetite			Painful joints			Difficulty urinating		
Shortness of breath at rest			Unexplained Weight Gain			Unexplained Weight Loss		
Heart trouble			Shortness of breath with exertion			Chest Pain		
Abdominal Pain			Swelling of ankles			Nausea/Vomiting		
Blood in urine			Diarrhea			Painful urination		