NEPHROLOGY ASSOCIATES of UTAH
Comprehensive Kidney Care

NEW PATIENT PAPERWORK & CLINIC POLICIES

Please complete the attached forms prior to your upcoming visit. Information needs to be provided to our physicians and medical staff for review to ensure the best care possible.
Please be aware of the following policies:

- We ask that all patients arrive 15 minutes prior to their scheduled appointment time for registration, check-in, and to complete any additional paperwork.
- All patients arriving more than 10 minutes past their scheduled appointment time will be rescheduled.
- Please call at least 48 hours prior to your schedule appointment to cancel or reschedule.

Please make certain to provide the following upon arrival:

1. **Completed new patient paperwork**
2. **Photo ID/driver license**
3. **Insurance cards**
4. **Payment method**

Please be prepared to provide a urine sample at scheduled visit

*** **NOTE: ALL COPAYS & PAST DUE BALANCES MUST BE PAID AT CHECK-IN** ***

Office contact information phone: 801-288-2634 fax: 801-288-1186

Main office address: 3702 S. State Street, Suite #107, Salt Lake City, Ut 84115

PATIENT QUESTIONNAIRE

Full Name: **DOB:**

Referring Provider: **Primary care physician:**

Preferred pharmacy:

Reason for referral:

REVIEW OF SYMPTOMS: INDICATE EACH SYMPTOM YOU ARE CURRENTLY EXPERIENCING:

☐ **Weight gain** ☐ **Weight loss** ☐ **Headaches** ☐ **Blurry vision** ☐ **Trouble breathing** ☐ **Palpitations**

☐ **Dizziness** ☐ **Chest pain** ☐ **Back pain** ☐ **Side/flank pain** ☐ **Abdominal pain** ☐ **Swelling in legs**

☐ **Vomiting** ☐ **Incontinence** ☐ **Foamy urine** ☐ **Blood in urine** ☐ **Urinary hesitancy** ☐ **Urinary urgency**

☐ **Diarrhea** ☐ **Burning/pain with urination** ☐ **Frequent urination *Number of nightly urinations:** _____

MEDICAL HISTORY: CURRENT AND PREVIOUS CONDITIONS:

☐ Kidney disease ☐ Chronic UTI's ☐ Cysts in kidney ☐ Heart failure ☐ Heart disease

☐ Kidney stones ☐ Bladder cancer ☐ Kidney cancer ☐ Prostate cancer ☐ Gout

DO YOU HAVE DIABETES? IF YES, PLEASE ANSWER THE FOLLOWING:

Date diagnosed: _____ **Do you have any tingling/numbness in hands or feet?** ☐ Yes ☐ No

Please list some average blood sugar readings: _____

_____

DO YOU HAVE HIGH BLOOD PRESSURE? IF YES, PLEASE ANSWER THE FOLLOWING:

Date diagnosed: _____ **Do you own a blood pressure cuff?** ☐ Yes ☐ No

Please list some average blood pressure readings: _____

_____

PROCEDURES: INDICATE IF YOU HAVE HAD ANY OF THE FOLLOWING:

☐ Kidney biopsy
Date: _____ Facility: _____

☐ Kidney transplant
Date: _____ Facility: _____

☐ Kidney/abdominal ultrasound
Date: _____ Facility: _____

☐ Kidney/abdominal CT scan
Date: _____ Facility: _____

FAMILY HISTORY: INDICATE THE FOLLOWING CONDITIONS ANY PARENTS, SIBLINGS, OR CHILDREN HAVE HAD:

☐ Kidney cancer ☐ Kidney disease ☐ Kidney stones ☐ Polycystic kidney disease

☐ Heart disease ☐ Hypertension ☐ Diabetes ☐ Prostate cancer

☐ Bladder cancer ☐ Enlarged Prostate *List other medical conditions run in the family:

_____

_____

LIST ANY OTHER MEDICAL CONDITIONS YOU CURRENTLY OR PREVIOUSLY HAVE BEEN TREATED FOR: _____

_____

HAVE YOU USED ANY OF THE FOLLOWING? IF YES, LIST START/STOP DATES & HOW OFTEN:

☐ **Tobacco:** _____

☐ **Alcohol:** _____

☐ **Recreational Drugs:** _____

DO YOU TAKE ANY OVER THE COUNTER HERBALS OR SUPPLEMENTS? IF YES, PLEASE LIST:

_____

_____

DO YOU USE ANY OVER THE COUNTER PAIN MEDICATIONS? (EXAMPLES: Tylenol, Ibuprofen, Advil, Aspirin, Motrin, Excedrin, etc.) IF YES, LIST MEDICATION, DOSE, AND HOW LONG:

_____

_____

DO YOU HAVE ANY MEDICATION ALLERGIES? IF YES, PLEASE LIST: _____

_____

LIST ALL CURRENT MEDICATIONS:	**DOSE:**	**AMOUNT/INSTRUCTIONS:**