Dialysis Associates
Patient Personal History

Patient Name:_____ **Date of Birth:**_____

Referring Physician:_____ **Phone #:**_____

Family History:

	Sex	Age	If Living Health	If Deceased Age at Death	Cause of Death
Father					
Mother					
Brothers/Sisters	M / F				
	M / F				
	M / F				
	M / F				
	M / F				
	M / F				
Husband/Wife					
Sons/Daughters	M / F				
	M / F				
	M / F				
	M / F				
	M / F				
	M / F				

Renal (Kidney) Disease:

Y N Do you have a history of kidney disease? If so, when were you first told of this?

_____

Y N Have you ever been found to have blood and/or protein in your urine? If so, when?

_____

Y N Do you have a history of kidney stones?

Y N Do you have a history of urinary tract/kidney infections? If so, about how often do you have an infection?

_____

Y N Have you ever been told that your kidneys were not functioning properly: If so, when?

_____

Dialysis Associates, P.A.

Patient consent and Acknowledgement of Receipt of Privacy Notice

I understand that as part of the providsion of healthcare services, Dialysis Associates, P. A. creates and maintains health records and other information describing among other things, my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment.

I have been provided with a Notice of Privacy Practices that provides a more complete description of the uses and disclosures of certain health information. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their Notice and practices and prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health healthcare operations (quality assessment and improvement activities, underwriting, premium rating, conducting or arranging for medial review, legal services and auditing functions, etc.) and that the organization is not required to agree to the restrictions requested.

By signing this form, I consent to the use and disclosure of protected health information about me for the purposes of treatment, payment and health care operations. I have the right to revoke this consent, in writing, except where disclosures have already made in reliance on my prior consent.

This consent is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed for reasons outside of treatment, payment or health care operations without my prior written authorization, except as otherwise provided by law.
2. A photocopy of fax of this consent is as valid as the original.
3. I have the right to request that the use of my Protected Health Information, which is used or disclosed for the purposes of treatment, payment or health care operations, be restricted. I also understand that the Practice and I must agree to any restriction in writing that I request on the use and disclosure of my Protected Health Information; and agree to terminate any restrictions in writing on the use and disclosure of my Protected Health information which have bee previously agreed upon.

Patient's Name Printed	Date
Patient's Signature (or Guardian, if a Minor)	Social Security # (for ID purposes only)
Witness (Optional)	Date

Revised October 7, 2002

Past History:

Write in the names and dates of any diseases you have had which required hospitalization:

Write in the names and dates of any serious illnesses you have had NOT requiring hospitalization:

Serious Operations, injuries, or accidents:

Do you know of any relative (mother, father, sister, or brothers) who has had: (Circle and give relationship)

Stroke:_____ Arthritis:_____

Cancer:_____ Tuberculosis:_____

Heart Disease:_____

Social History:

Y N Do you smoke? If so, how many per day? _____How long?_____

Y N Do you regularly drink alcohol? If so, about how many drinks per week? _____

Medications:

Please list all other medications, both prescribed and over the counter which you are presently taking:

Y N Do you have difficulty beginning urination?

Y N Is your urine stream as strong as ever?

Y N Do you frequently stop urinating and then resume with a fairly large volume?

Y N Have you ever had prostate trouble? Surgery? Y N If so, When?_____

Y N Do you have problems with swelling (edema)?

Y N Do you have problems with shortness of breathe?

Y N Do you have any history of heart disease? If so, what type?_____

Y N Do you have chest pain or fullness in your chest?

Y N Do you have palpitations (heart "fluttering")?

Do you have a history of any of the following?

Y N Recent (within 6 months) sore throat?

Y N Recent (within 6 months) skin infections?

Y N Arthritis? If so, what medications (either prescribed or over the counter were used?_____

_____

Y N Unexplained skin Rash?

Y N Frequent use of pain medications – both prescribed and over the counter?

Y N Family history of renal (kidney) disease? If so, describe:

Y N Coughing up blood?

Y N Recent loss of appetite?

Y N Nausea and vomiting?

Y N Jerking of your arms or legs?

Y N Forgetfulness or lack of concentration?

Hypertension:

Y N Have you ever been told that your blood pressure was too high? If so, when?_____

_____

Y N Have you ever been diagnosised as having high blood pressure (hypertension)? Is so, when?_

_____

Y N Are you currently on medication for high blood pressure? If so, please list:

DRUG	STRENGTH	FREQUENCY

Y N Do you avoid salt?

Y N Do you have a family history of high blood pressure?

Diabetes:

Y N Do you have diabetes: If so, when was this disease first diagnosed?

Y N IF so, are you on treatment? What type of treatment? Diet:_____

Oral Drugs: Insulin:_____ Type and dose of Insulin:_____

Y N Do you check blood sugars at home? If so, what is a typical:

A.M. blood sugar:_____ P.M. blood sugar:_____

Y N Do you have numbness in your feet?

Y N Do you have problems with frequent vomiting?

Y N Do you have problems with frequent diarrhea or constipation?

Y N Do you have visual difficulty?

Y N Have you ever had laser therapy?

Systemic Review:

Y N Do you have any history of: (circle Y or N)

Y N Frequent headaches

Y N Migraine

Y N Seizures

Y N Chronic cough

Y N Sputum production

Y N Pneumonia

Y N Night sweats

Y N Heart murmur

Y N Rheumatic fever

Y N Ulcers of GI bleeding

Y N Liver disease or jaundice

Y N Recent weight loss

Y N Recent fevers