New Patient Form

LINCOLN NEPHROLOGY & HYPERTENSION PC

7401 O Street, Lincoln, NE 68510 | 402-484-5600 | Fax: 402-484-5630 | lincolnnephrology.com

Welcome to Lincoln Nephrology and Hypertension. Thank you for trusting us with for your health care. Please complete the following in order to help us take the best possible care of you.

DEMOGRAPHICS

Date of Birth: _____

Last Name: _____ First Name: _____ Middle Initial: _____

Address: _____ City: _____

State: _____ Zip: _____

Phone: _____ Cell: _____

Email (for appt. reminders only): _____

Emergency Contacts: Primary: _____

Secondary: _____

To whom can we release information about your care? _____

Primary Care Provider: _____

Other providers involved in your care: _____

PERSONAL/SOCIAL HISTORY

What is your marital status?

☐ Married ☐ Single ☐ Divorced ☐ Widowed

Occupation: _____

With whom do you live? _____

Check all that apply to you:

☐ I have never smoked or used chewing tobacco.

☐ I currently smoke cigarettes or cigars or use chewing tobacco.

How long have you smoked/chewed tobacco? _____

How many packs/cans do you use a day? _____

☐ I have used cigarettes, cigars, or smokeless tobacco in the past, but I do not currently.

When did you quit using tobacco? _____

☐ I drink alcohol on a daily/weekly/monthly basis (circle one if applicable).

☐ I rarely or occasionally drink alcohol.

☐ I used to drink alcohol on a regular basis, but I do not drink currently.

How long ago did you quit? _____

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MEDICAL HISTORY

Please check any conditions below you are being treated for and the year it was diagnosed (if known).

☐ High Blood Pressure
Year _____

☐ Diabetes
Year _____

☐ Eye Problems from Diabetes
Year _____

☐ Nerve Damage from Diabetes
Year _____

☐ Heart Attack
Year _____

☐ Stents in Heart
Year _____

☐ Irregular Heart Rhythm
Year _____

☐ Heart Failure
Year _____

☐ High Cholesterol
Year _____

☐ Sleep apnea
Year _____

☐ Anxiety
Year _____

☐ Stroke
Year _____

☐ Lung Disease
Year _____

☐ Asthma
Year _____

☐ Bronchitis
Year _____

☐ Heartburn (Acid Reflux)
Year _____

☐ Ulcers in Stomach or Intestine
Year _____

☐ Liver Disease
Year _____

☐ Hepatitis
Year _____

☐ Enlarged Prostate
Year _____

☐ Recurrent UTI
Year _____

☐ Depression
Year _____

☐ Blood clots
Year _____

☐ Cancer
Year _____

☐ Arthritis
Year _____

☐ Gout
Year _____

☐ Thyroid Disease
Year _____

☐ Seizures
Year _____

☐ Migraine Headaches
Year _____

☐ Kidney Stones
Year _____

☐ Cysts of the Kidney
Year _____

☐ Edema (swelling)
Year _____

Please list any other medical conditions that you have or had in the past, including injuries or illness that required hospitalization: _____

_____

_____

_____

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Please list any surgeries you have had and the year performed:

_____

_____

_____

_____

CURRENT MEDICATIONS

Please list any medications you take regularly (prescription or over-the-counter): _____

_____

_____

_____

_____

☐ Medication list has been photocopied and attached to this form OR see additional sheets.

Are you allergic to any medications? ☐ YES ☐ NO

If Yes, please complete the following

Medication	Type of Reaction

Have you taken or currently taking any of the following medications? Ibuprofen, Motrin, Advil, Aleve, Naprosyn/Naproxen, Mobic, Celebrex, Vioxx, Bextra, Diclofenac, Voltaren, or Nabumetone?

☐ YES ☐ NO

If yes, how much do you take and how often?_____

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FAMILY HISTORY

Please check if your parents, siblings, or children have had or have any of the following conditions:

☐ Anemia	☐ Diabetes	☐ Kidney disease
☐ Coronary Artery Disease	☐ High cholesterol	☐ Kidney stones
☐ Cancer	☐ High blood pressure	☐ Stroke

Other family history not listed above :_____

REVIEW OF SYSTEMS

Please check "YES" or "NO" to any of the following symptoms that you have had in the last 3 months:

GENERAL

YES	NO	
☐	☐	Fever
☐	☐	Weight Loss (How much _____)
☐	☐	Weight Gain (How much _____)
☐	☐	Fatigue

EYES

YES	NO	
☐	☐	Sudden change in vision
☐	☐	Eye pain
☐	☐	Light sensitivity

EARS, NOSE, MOUTH, THROAT

YES	NO	
☐	☐	Ringing in ears
☐	☐	Nasal drainage
☐	☐	Nosebleed

MUSCULOSKELETAL

YES	NO	
☐	☐	Muscle weakness
☐	☐	Muscle cramps
☐	☐	Muscle pain
☐	☐	Joint pain

SKIN

YES	NO	
☐	☐	Rash or itching
☐	☐	Skin cancer

NEUROLOGIC

YES	NO	
☐	☐	Weakness
☐	☐	Tingling
☐	☐	Numbness
☐	☐	Seizures

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CARDIOVASCULAR

YES	NO	
☐	☐	Chest pain
☐	☐	Orthopnea
☐	☐	Swelling of the arms or legs
☐	☐	Shortness of breath when lying flat

RESPIRATORY

YES	NO	
☐	☐	Cough
☐	☐	Sputum production
☐	☐	Shortness of breath at rest
☐	☐	Shortness of breath with activity

GASTROINTESTINAL

YES	NO	
☐	☐	Abdominal pain
☐	☐	Mass/masses in the abdomen
☐	☐	Nausea and/or vomiting
☐	☐	Diarrhea
☐	☐	Dark/tarry stools
☐	☐	Bright red blood in the stools

GENITOURINARY

YES	NO	
☐	☐	Burning with urination
☐	☐	Blood in the urine
☐	☐	Urinary frequency or urgency
☐	☐	Frequent urination at night

PSYCHIATRIC

YES	NO	
☐	☐	Depression
☐	☐	Anxiety
☐	☐	Thoughts of suicide

ENDOCRINE

YES	NO	
☐	☐	Excessive thirst
☐	☐	Excessive hunger
☐	☐	Excessive heat
☐	☐	Excessive cold
☐	☐	Thyroid problems

HEMATOLOGIC

YES	NO	
☐	☐	Abnormal bruising
☐	☐	Abnormal bleeding

IMMUNOLOGIC

YES	NO	
☐	☐	Seasonal allergies/hay fever

Other symptoms:_____

_____

_____

_____