Date_____

INITIAL HEALTH QUESTIONNAIRE

Name: _____ Phone #: C_____ H_____ W_____
Home Address: _____ DOB: ____/____/____ Age: _____
City, State, Zip: _____ E-Mail: _____
Emergency Contact: _____ Relationship: _____ Phone #: _____

What is the main symptom/issue that brought you in to see the doctor today? Name of doctor who referred you: _____
_____

PAST HISTORY

Check all that apply (note year of diagnosis)

☐ Diabetes Date: _____
☐ Hypertension Date: _____
☐ Anemia Date: _____
☐ Kidney Disease Date: _____
☐ Kidney Stones Date: _____
☐ Liver Disease Date: _____
☐ Cancer Date: _____
☐ Immune Disorder Date: _____
☐ Heart Disease Date: _____

Details/other: _____
_____
_____

List all Operations with Approximate Date:
_____
_____
_____

DAILY HABITS

How many cups of coffee do you drink? _____
Have you ever used cigarettes? Yes or No
How many daily? _____ Years? _____
How many Alcoholic drinks daily? _____

MEDICATIONS

List or attach all currently prescribed medications:
_____
_____
_____
_____
_____

List or attach all OTC medications (vitamins, supplements, etc.): _____
_____

Pharmacy: _____

ALLERGIES

List all medicine and exposure allergies with reactions:
_____
_____

FAMILY HISTORY

Any family member (parents, siblings, children) with diabetes, cancer, heart or kidney diseases?
_____
_____
_____

PERSONAL/SOCIAL HISTORY

Occupation: _____
Religion: _____

OTHER PHYSCIANS

Other physicians you are currently seeing (Primary care, Cardiology, GI, etc.):
_____
_____
_____
_____

I authorize the release of all medical records to referring physicians and to my insurance company. I further authorize insurance payments to be made directly to Santa Barbara Nephrology. I understand payment is due at time of service.

Signature:

_____

Date: _____