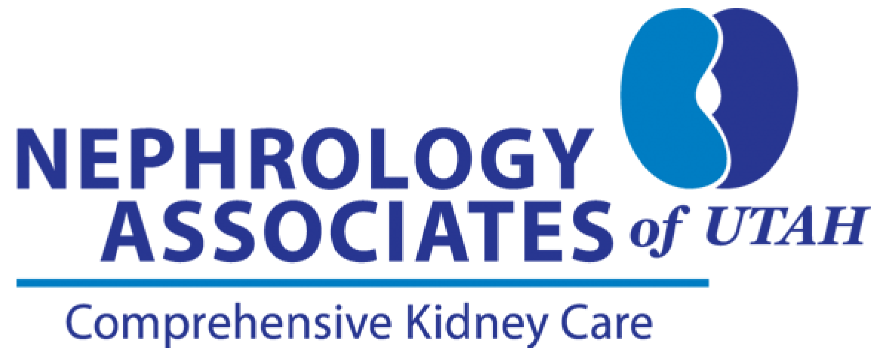

NEW PATIENT PAPERWORK & CLINIC POLICIES

Please complete the attached forms before 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:

1. We ask that all patients arrive 15 minutes early to their scheduled appointment time for registration, check-in, and to complete any additional paperwork.

2. All patients arriving more than 10 minutes late to their scheduled appointment time will be rescheduled.

3. Please call at least 48 hours before your scheduled appointment to cancel or reschedule.

4. All patients who have 3 or more "no-shows" will be discharged from our clinic.

Please be prepared to provide a urine sample at the 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 : ____ Date of Birth :____________

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 ☐ 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 your 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 ☐

Facility : ___________________ Date : __________

Kidney Transplant ☐

Facility : ___________________ Date :__________

Kidney/ abdominal Ultrasound ☐

Facility : ___________________ Date : __________

Kidney / abdominal CT ☐

Facility : ___________________ Date : __________

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 ☐ Autoimmune disease ☐ Enlarged Prostate ☐ Anemia

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 and how often :

☐ Tobacco: ____

☐ Alcohol: ____

☐ Recreational Drugs: ____

Do you take any over-the-counter herbs or supplements? If yes, please list :

____

____

____

Do you take any over-the-counter pain medications? (I.e. Tylenol, Ibuprofen, Advil, Aspirin, Motrin, Excedrin, etc.) If yes, list the medication, dose, and how long you have been taking the medication :

____

____

____

Do you have any medication allergies? If yes, please list the medication and the reaction :

____

____

____

Please review the attached medication list. Cross out or “X” the medications you are no longer taking and “+” add medications that are missing from your list. Be sure to note the dose and the frequency (once a day, twice a day, weekly, monthly, etc.)