PLEASE COMPLETELY FILL OUT PACKET AND MAIL BACK IN THE ENVELOPE PROVIDED. THANK YOU.

Advanced
NEPHROLOGY ASSOCIATES, PC
SPECIALIZING IN NEPHROLOGY AND HYPERTENSION

New Patient Registration Form

Avalon: 412-766-3232 Hermitage: 724-346-0400

Name: ☐ M ☐ F						**Today's date**
Address:						**Email Address:**
Marital status:	☐ Single	☐ Partnered	☐ Married	☐ Separated	☐ Divorced	☐ Widowed
Social Security:						**Date of Birth:**
Home Phone:						**Cell Phone:**
Emergency Contact:						**Relationship:**
Emergency Phone#:						**Emergency Cell#:**
Are you Employed?						**Employer:**

Referring Physician:

Reason:

Have you ever been seen by any of our physicians previously? Please circle.	
Gabriel T. Weinberg, M.D.	Nimish S. Naik, M.D.
Samuel C. Baroody D.O	Yuva Timsina, CRNP
Parineesha Nath M.D.	Valerie Dodds, CRNP

Have you ever been seen by a Nephrologist/Kidney Doctor in the past? If so, who?_____

INSURANCE

Primary Insurance:	Policy Holder:
ID#	
Group #	Policy Holder Date of Birth:
Secondary Insurance:	
ID #	
Group#	
PCP Name:	
PCP Address and Phone Number:	
Pharmacy:	
Hospital of Preference for Admission:	
Lab of Preference:	

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

EXERCISE	☐ None (No exercise)				
	☐ Occasional (i.e., climb stairs, walk 3 blocks, golf)				
	☐ Moderate (i.e., work or recreation, less than 4x/week for 30 min.)				
	☐ Heavy (i.e., work or recreation 4x/week for 30 minutes)				
DIET	Do you follow any dietary restrictions?			☐ Yes	☐ No
	If yes, are you following a physician-recommended medical diet?			☐ Yes	☐ No
	Please indicate below which diet you follow (if any):				
	☐ Regular	☐ Vegetarian	☐ Weight Watchers	☐ Specific	
	☐ Vegan	☐ Gluten-free	☐ Diabetic	☐ Cardiac	
CAFFEINE	Do you drink any caffeinated beverages?			☐ Yes	☐ No
	What type of beverages? ☐ Coffee ☐ Soda ☐ Tea ☐ Other:				
	How many servings/cups per day?				
ALCOHOL	Do you drink alcohol?			☐ Yes	☐ No
	Level of consumption? ☐ Occasional (<1 drink/day) ☐ Moderate (~1 drink/day) ☐ Heavy (1+ drink/day)				
TOBACCO	Do you currently use any tobacco products?			☐ Yes	☐ No
	Have you ever used any tobacco products?				
	Type: ☐ Cigarettes ☐ Cigars ☐ Chew ☐ Pipe tobacco				
	Frequency (packs per day, etc):				
PERSONAL SAFETY	Do you live alone?			☐ Yes	☐ No
	Do you have frequent falls?			☐ Yes	☐ No
	Do you have vision loss?			☐ Yes	☐ No
	Do you have hearing loss?			☐ Yes	☐ No
	Do you have an Advance Directive or Living Will?			☐ Yes	☐ No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**	☐ M ☐ F	
Mother				☐ M ☐ F	
Siblings	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**Grandmother** *Maternal*		
	☐ M ☐ F		**Grandfather** *Maternal*		
	☐ M ☐ F		**Grandmother** *Paternal*		
	☐ M ☐ F		**Grandfather** *Paternal*		

PERSONAL HEALTH HISTORY

SURGERIES

Year	Reason	Hospital

OTHER HOSPITALIZATIONS

Year	Reason	Hospital

PERSONAL HEALTH HISTORY (continued)

Please indicate below if you have ever had any of the following conditions:

☐ Abdominal Aortic Aneurysm Repair	☐ Hypertension (high blood pressure)
☐ Acid Reflux (GERD)	☐ Hypokalemia (low blood levels of potassium)
☐ Anemia	☐ Hyponatremia (low blood levels of sodium)
☐ Anxiety	☐ Kidney Cysts
☐ Arthritis	☐ Kidney Disease
☐ Asthma	☐ Kidney Failure
☐ Atrial Fibrillation	☐ Kidney Stones
☐ Blood Transfusions	☐ Liver Disease
☐ Cancer Type:	☐ Lupus
☐ Chronic Kidney Disease	☐ NSAID use
☐ COPD (Chronic Obstructive Pulmonary Disease)	☐ Neuropathy
☐ Congestive Heart Failure	☐ Obesity
☐ Coronary Artery Disease	☐ Organ Transplant
☐ Depression	☐ Peripheral Vascular Disease
☐ Diabetes	☐ Prostate Hypertrophy
☐ Edema	☐ Proteinuria (protein in urine)
☐ Gout	☐ Renal Insufficiency
☐ Heart Disease	☐ Seizures/Epilepsy
☐ Hematuria (blood in urine)	☐ Sleep Apnea
☐ Hepatitis B	☐ Stroke
☐ High Cholesterol	☐ Thyroid Problems
☐ Hyperkalemia (high blood levels of potassium)	☐ Urinary Tract Infections
☐ Hyperlipidemia	☐ Varicose Veins
☐ Hypernatremia (high blood levels of sodium)	☐ Vitamin D Deficiency
☐ Hyperparathyroidism	☐ Other:

Please list your prescribed medications, including over-the-counter drugs (vitamins, supplements, etc)		
Drug Name	Strength (mg, mcg, etc)	Frequency Taken (daily, twice daily, etc)

MEDICATION ALLERGIES

Drug Name	Reaction

All questions contained in this questionnaire are strictly confidential.