Nephrology and Internal Medicine of Anderson

Ralph Henry. M.D. - Muhammad Shakeel. M.D. - Zia Din. M.D. - Anthony Joseph. M.D.
Kelly Herring. N.P. – Ivy Ray. N.P.

779 Senate Parkway Anderson, SC 29621
Phone 864-224-8716 / Fax 864-226-2287

Patient Full Name: ____Date of Birth:_____________

Social Security Number: _______________________Gender: _________________

Marital Status: ___________________ Race:___________________

Mailing Address: ____

City: ____________________ State: _____________ZIP: ____________________

Home Phone Number: ________________________Cell Phone Number:____________________

Email Address: ____

Emergency Contact Name & Number: ____

____

Primary Care Provider Name: ____

*****Please bring all forms completed, along with insurance cards and updated list of medications and/or bottles of your medications*****

Nephrology and Internal Medicine of Anderson

New Patient Form

Name: ______________________________ **DOB:** ______________

Primary Care Provider: ______________________________

Medication Allergies: ______________________________

____

Past Medical History (circle all that apply)

Proteinuria	Atrial Fibrillation	COPD	ADD/ADHD
Autoimmune Disease	Dementia	Anemia	Cancer __________
Dizziness	Arthritis	Diabetes ______________	
Heart Disease	Congestive Heart Failure		
Neuropathy	GERD	Hematuria	Lupus
Asthma	Hearing Problems	Headaches	Liver Disease
High Blood Pressure	High Cholesterol	HIV/AIDS	Seizures
Stroke	Seasonal Allergies	Kidney Disease _________	
Thyroid Disease	Hyperkalemia	Acute Kidney Injury	
Kidney Stones	PCOS	Renal Cyst	
Urinary Tract Infection	Other – list below		

____

____

Surgical History

____

____

Family History (Please check and specify if possible)

	Cancer	Diabetes	Kidney Disease	Hypertension	Stroke	Heart Disease
Mother						
Father						
Sister						
Brother						
MGM						
MGF						
PGM						
PGF						

Other ____

____

Tobacco use (circle all that apply)

Current / Former / Never used

Cigarettes / Pipes / Cigars / Snuff / Chewing Tobacco

Alcohol use (circle all that apply)

Current / Former / Never used

Occasional / 1-2 per day / 3 or more per day

Recreational Drug Use (circle all that apply)

Current / Former / Never used

Marijuana / Amphetamines / LSD / Heroin / Ecstasy / Opium / Cocaine / Barbiturates

Other________________________

Pharmacy: ____

Medications (Please list name, dose and directions)

____

____

____

____

____