Nephrology and Internal Medicine of Anderson

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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)

_____

_____

_____

_____

_____