**UNIVERSITY NEPHROLOGY**

1932 ALCOA HIGHWAY, SUITE 460

KNOXVILLE, TN 37920-1511

Phone (865) 546-9246 Fax (865)523-6466

**DENISE RIVERS, DO - URATH SURESH, MD - ROSS NESBIT, MD - RITU KHANNA, MD**

**STEPHANIE M. BURGETT, MSN, APRN-BC – KAITLIN GREEN, FNP-BC – ANDREW BROWER, FNP-BC – KACI NEWLIN, FNP-BC**

**PATIENT INFORMATION**

DATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE OF BIRTH \_\_ / / . AGE \_\_\_\_\_\_\_\_\_\_ SEX M / F

 (LAST) (FIRST) (M.I.)

ADDRESS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ APT/UNIT\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CITY\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ STATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ZIP CODE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HOME PHONE ( ) EMPLOYER\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ALTERNATE ( ) ADDRESS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CELL PHONE ( ) WORK PHONE ( )

**SS#**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ EMAIL\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MARITAL STATUS:** Single / Married / Widowed / Divorced / Separated **LIVING ARRANGEMENT:** with – Spouse / Independently / Caregiver or Family

**RACE**: White / Black / Native American / Asian / Native Hawaiian / Other **PRIMARY LANGUAGE**: English / Spanish / Italian / Hindi / Other

**ETHNICITY**: Non-Hispanic or Non-Latino / Hispanic or Latino

SPOUSE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE OF BIRTH / / .

ADDRESS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ HOME PHONE (\_\_\_\_\_\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMPLOYER\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ WORK PHONE (\_\_\_\_\_\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CELL PHONE (\_\_\_\_\_\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMERGENCY CONTACT\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ RELATIONSHIP\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ HOME PHONE ( \_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 WORK PHONE ( \_\_\_\_\_ ) \_\_\_\_\_\_\_\_\_\_ CELL PHONE ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

REFERRING PHYSICIAN \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHONE ( \_\_\_\_\_ )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ FAX # ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

OTHER PHYSICIANS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHONE ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**PHARMACY (including address)** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHONE ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**PRIMARY INSURANCE**

INSURANCE CO. NAME \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHONE ( \_\_\_\_ )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ID # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ GROUP # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SECONDARY INSURANCE**

INSURANCE CO. NAME \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHONE ( \_\_\_\_ )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ID # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ GROUP # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**STEPHANIE M. BURGETT, MSN, APRN-BC – KAITLIN GREEN, FNP-BC – ANDREW BROWER, FNP-BC – KACI NEWLIN, FNP-BC**

PATIENT’S NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. May we leave confidential messages with anyone answering the telephone on your home/cell number?

 Yes No

1. May we leave confidential messages regarding appointments, return calls for test results, etc. on your home/cell voicemail? Yes No
2. May we leave confidential messages with anyone answering the telephone regarding appointments, lab results or other healthcare information at numbers other than your home phone number? Yes No

If yes, please list numbers: (\_\_\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_; (\_\_\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. If we are unable to reach you by any of the above options, may we leave confidential messages at your place of employment?

Yes No

1. **ONLY** release informationto those I list (Please give full names):

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Check this box only if you **DO NOT** want any information released to anyone, including your spouse and/or other household members.

If we are unable to reach you by any other means, we will send information through the U.S. Postal Services to your home address.

I acknowledge I have received a copy of the Notice of Privacy Practices and have been given the opportunity to read it, have it explained to me, and ask questions. I understand that this Notice describes how my health information may be used or disclosed by University Nephrology of Knoxville and its physicians and other providers and that I should read it carefully. I am aware that the Notice may be changed at any time, and I may obtain a revised copy of the Notice by contacting the office.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Signature of Patient Date

**RELEASE AUTHORIZATION/ASSIGNMENT**

I request that payment of the authorized insurance benefits be made on by behalf to UNIVERISTY NEPHROLOGY OF KNOXVILLE for any services furnished to me by that provider. I authorize any holder of medical information about me to release to the HEALTH CARE FINANCING ADMINISTRATION and its agents any information needed to determine these benefits or the benefits payable for the related services.

I authorize the billing of my Medigap insurers, if applicable, on my behalf and request payment to UNIVERSITY NEPHROLOGY OF KNOXVILLE for any services furnished to me by that provider.

I authorize any physician examining and/or treating me to release to any third party (such as an insurance company or government agency) any medical information requested for use in determining claim for payment. I also request payment benefit to UNIVERSITY NEPHROLOGY OF KNOXVILLE.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient Date

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**NAME:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **REFERRING DOCTOR:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PRESENT HEALTH CONCERNS RELATING TO VISIT TODAY: \_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**ALLERGIES TO MEDICATIONS (Please indicate if None Known):**

|  |  |
| --- | --- |
| **MEDICATION** | **REACTION OR SIDE EFFECT** |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

**MEDICATIONS:**

|  |  |  |
| --- | --- | --- |
| **MEDICATION** | **DOSE** | **TIMES PER DAY** |
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| --- | --- | --- |
| **MEDICATION** | **DOSE** | **TIMES PER DAY** |
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**PERSONAL MEDICAL HISTORY:**

Please indicate whether you have/have had any of the following medical problems (with approximate date of illness or diagnosis):

\_\_\_\_\_Vision Problems \_\_\_\_\_Hepatitis

\_\_\_\_\_Blindness \_\_\_\_\_Frequent Urinary Tract Infections

\_\_\_\_\_Cataracts \_\_\_\_\_Problems Urinating

\_\_\_\_\_Hearing problems \_\_\_\_\_Prostate Problems

\_\_\_\_\_High Blood Pressure \_\_\_\_\_Kidney Stones

\_\_\_\_\_Heart Attack/MI \_\_\_\_\_Stroke

\_\_\_\_\_Irregular Heartbeat \_\_\_\_\_Seizures

\_\_\_\_\_Pacemaker/Defibrillator \_\_\_\_\_Paralysis/Weakness

\_\_\_\_\_Congestive Heart Failure \_\_\_\_\_Thyroid Problems

\_\_\_\_\_COPD/Emphysema \_\_\_\_\_Diabetes

\_\_\_\_\_Pneumonia \_\_\_\_\_Arthritis

\_\_\_\_\_Tuberculosis \_\_\_\_\_Gout

\_\_\_\_\_Asthma \_\_\_\_\_Anemia

\_\_\_\_\_Heartburn/Gastric Reflux \_\_\_\_\_Lupus

\_\_\_\_\_Stomach Ulcers \_\_\_\_\_Depression

\_\_\_\_\_Bowel Disease \_\_\_\_\_HIV

\_\_\_\_\_Gall Bladder Disease \_\_\_\_\_Cancer (Type): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SURGICAL HISTORY** (Please list all prior operations and dates):

|  |  |
| --- | --- |
| **OPERATION** | **DATE** |
|  |  |
|  |  |
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|  |  |

|  |  |
| --- | --- |
| **OPERATION** | **DATE** |
|  |  |
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**IMMUNIZATIONS:** Pleas list most recent immunizations and dates

\_\_\_\_\_ Hepatitis A \_\_\_\_\_ Measles

\_\_\_\_\_ Hepatitis B \_\_\_\_\_ MMR

\_\_\_\_\_ Tetanus (Td) \_\_\_\_\_Varicella (chicken pox)

**SOCIAL HISTORY**

\_\_\_\_\_Right Handed \_\_\_\_\_Left Handed

Highest Education Level Completed: \_\_\_\_\_Grade School \_\_\_\_\_High School \_\_\_\_\_GED \_\_\_\_\_College \_\_\_\_\_Graduate School

**Tobacco Use**:

 Cigarettes:

 Never

 Quit Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Current Smoker: \_\_\_\_\_packs/day \_\_\_\_\_# of yrs

 Other Tobacco: Pipe / Cigar / Snuff / Chew

**FAMILY HISTORY**

Please indicate family members who have had any of the following:

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Medical Cond.** | Mom | Dad | Sis | Bro | Daug | Son | Other |
| Alcoholism |  |  |  |  |  |  |  |
| Anemia |  |  |  |  |  |  |  |
| Anesthesia Prob |  |  |  |  |  |  |  |
| Asthma |  |  |  |  |  |  |  |
| Birth Defects |  |  |  |  |  |  |  |
| Bleeding Prob |  |  |  |  |  |  |  |
| Cancer, Breast |  |  |  |  |  |  |  |
| Cancer, Colon |  |  |  |  |  |  |  |
| Cancer, Skin |  |  |  |  |  |  |  |
| Cancer, Ovary |  |  |  |  |  |  |  |
| Cancer, Prostate |  |  |  |  |  |  |  |
| Cancer, Other |  |  |  |  |  |  |  |
| Depression |  |  |  |  |  |  |  |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Medical Cond.** | Mom | Dad | Sis | Bro | Daug | Son | Other |
| Hay Fever |  |  |  |  |  |  |  |
| Hearing Prob |  |  |  |  |  |  |  |
| Heart Attack |  |  |  |  |  |  |  |
| High Blood Pressure |  |  |  |  |  |  |  |
| High Cholesterol |  |  |  |  |  |  |  |
| Kidney Disease |  |  |  |  |  |  |  |
| Lupus |  |  |  |  |  |  |  |
| Mental Retardation |  |  |  |  |  |  |  |
| Migraines |  |  |  |  |  |  |  |
| Mitral Valve Prolapse |  |  |  |  |  |  |  |
| Osteoarthritis |  |  |  |  |  |  |  |
| Osteoporosis |  |  |  |  |  |  |  |
| Rheumatoid Arthritis |  |  |  |  |  |  |  |
| Seizures |  |  |  |  |  |  |  |
| Stroke |  |  |  |  |  |  |  |
| Thyroid Disorders |  |  |  |  |  |  |  |
| Tuberculosis |  |  |  |  |  |  |  |
| Other: |  |  |  |  |  |  |  |

If deceased, please provide **AGE** and **CAUSE OF DEATH**

Mother: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Father: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Siblings: ­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Children: ­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_ Pneumovax (Pneumonia) \_\_\_\_\_ Mumps

\_\_\_\_\_ Influenza (FLU) \_\_\_\_\_ Rubella

\_\_\_\_\_ Shingles \_\_\_\_\_ Other

Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Previous types of jobs held\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Alcohol Use**:

Do you drink alcohol? No / Yes: \_\_\_\_\_ # drinks/week

Have you ever had Toxic Exposures (fumes, chemicals, etc)?

 \_\_\_\_\_No \_\_\_\_\_Yes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Illicit Drug Use:** Currently / Quit / Never

**What are some of your stress issues?**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_