NEPHROLOGY ASSOCIATES OF MICHIGAN, P.C.

Patient Name_____ DOB_____

Primary Physician_____ Today's Date_____

Height_____Weight_____ BP (left arm/right arm) _____Pulse_____

Write Yes or No if you have developed any of the following *since you were seen last*?

Do you smoke_____ Quit, When? _____

Have you been hospitalized since last visit? _____If so where?_____

Do you have an advance directive? _____

	YES	NO		YES	NO
Fevers	____	____	Black Tarry Stools	____	____
Weight Change	____	____	Bloody Stools	____	____
Loss of Appetite	____	____	Painful Urination	____	____
Daytime Sleepiness	____	____	Bloody Urine	____	____
Rash	____	____	Passed Stone/Gravel	____	____
Itching (pruritis)	____	____	Difficulty Urinating	____	____
Skin Ulcers	____	____	Headache	____	____
Easy Bruising/Skin	____	____	Muscle Weakness	____	____
Sudden Vision Loss	____	____	Joint Pain/Swelling	____	____
Sudden Hearing Loss	____	____	Leg Swelling	____	____
Nosebleed	____	____	Calf Pain (when walking)	____	____
Metallic Taste	____	____	Fainting	____	____
Difficulty swallowing	____	____	New Shakes/tremors	____	____
Shortness of Breath	____	____	Swollen Lymph Nodes	____	____
Cough	____	____	Increased Thirst	____	____
Chest Pains	____	____	Slurred Speech	____	____
Irregular Heartbeat	____	____	Night Sweats	____	____
Abdominal pain	____	____	Persistent Hiccups	____	____
Nausea or vomiting	____	____	Family Illness	____	____
Diarrhea	____	____	New Allergy Reaction	____	____
			Employment Change	____	____

Have you had any immunizations? If so Which?	**Dates of Immunizations-**

For office use only:

Vitals	Soc Hist	Dr First Review	Pharmacy
BMI Sheet-	Smoking Cessation-	Family History?	