**Nephrology**



2301 House Ave., Suite 201 • Cheyenne, WY 82001 • (307) 638-7757 • cheyenneregional.org

Date:

**Name:**

**Date of Birth:**

**Appointment Scheduled:**

To assist us in providing the best care possible, we ask for your assistance in the following areas:

1. Please ask your referring provider to send any records, labs, radiology reports, etc. that may pertain to their referral.
2. Please show up 15 minutes early for your appointment so our front office staff will be able to check you in in a timely manner. **Patients that are more than 10 minutes late may be rescheduled to a later time or date.**
3. Please bring a list of your current medications, prescribed and over the counter.
4. **Kidney Patients:** New patients will be asked to provide a urine sample on their first visit.

Please bring your **Insurance Card**, **Copayment** and a **Photo ID.**

If you do not have Medical Insurance or CRMC Charity Care your **NEW PATIENT VISIT DEPOSIT IS $180.00** and your **FOLLOW UP VISIT DEPOSIT IS $120.00.** This is required at the time of service and is not the total cost of your appointment.

We look forward to seeing you soon. If you have any questions or need to reschedule your appointment, **please call the office at 307-638-7757.**

Thank you,

The Medical Specialty Clinic Staff

Medical Specialty Clinic – Nephrology  
Health History Questionnaire

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Prefer to be called: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_**

**Marital Status:**

◊ Single ◊ Married ◊ Widowed ◊ Divorced ◊ Separated

**Employment:**  
◊ Full-time ◊ Part-time ◊ Retired ◊ Disability

**Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Job Description: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Primary Care Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   
Heart Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Diabetes Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Urologist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   
Surgeon: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Other Doctors \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |
| --- | --- |
| Personal Health History | |
| **Exercise** | ◊ Sedentary (no exercise) |
|  | ◊ Mild (i.e., climb stairs, golf, walk 3 blocks |
|  | ◊ Occasional vigorous (<4x/wk for 30 min) |
|  | ◊ Regular vigorous (>4x/wk for 30 min) |
| **Dieting?** ◊ Yes ◊ No | Type: |
| **Salt Intake** | ◊ High ◊ Medium ◊ Low |
| **Caffeine** | ◊ None ◊ Coffee ◊ Tea ◊ Cola |
|  | # cups/cans per day? |
| **Alcohol** ◊ Yes ◊ No | # drinks per week? |
| **Tobacco** ◊ Yes ◊ No ◊ Former | ◊ Cigarettes – list # packs per day ◊ Chew – list # per day ◊ Pipe / Cigars – list # per day |
|  | ◊ Number of years ◊ Year quit |
| **Drugs** | Currently use street/recreational drugs? ◊ Yes ◊ No |
|  | Ever used street/recreational drugs? ◊ Yes ◊ No |
|  | Ever injected drugs with a needle? ◊ Yes ◊ No |
| **Exposures** | Ever had yellow jaundice or hepatitis? ◊ Yes ◊ No |
|  | Ever had a blood transfusion? ◊ Yes ◊ No When? |
|  | Ever been exposed to heavy metals? ◊ Lead ◊ Mercury ◊ Cadmium ◊ Other |

**Preventative Services & Dates:**  
◊ Colonoscopy \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
◊ Mammogram \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
◊ Rectal Exam \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Is there a family history of: List Relative (s)**

Kidney Disease? ◊Yes ◊ No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Kidney Stones? ◊ Yes ◊ No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dialysis? ◊ Yes ◊ No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

High blood pressure? ◊ Yes ◊ No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

High cholesterol? ◊ Yes ◊ No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Heart disease? ◊ Yes ◊ No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diabetes? ◊ Yes ◊ No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cancer? ◊ Yes ◊ No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Stroke? ◊ Yes ◊ No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Anemia? ◊ Yes ◊ No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hearing Loss? ◊ Yes ◊ No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Lupus? ◊ Yes ◊ No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| --- | --- | --- |
| Family Health History | | |
|  | Age | Health Problems |
| **Father** | Alive Dead |  |
| **Mother** | Alive Dead |  |
| **Brothers** | Alive Dead |  |
|  | Alive Dead |  |
|  | Alive Dead |  |
| **Sisters** | Alive Dead |  |
|  | Alive Dead |  |
|  | Alive Dead |  |
| **Sons** | Alive Dead |  |
|  | Alive Dead |  |
|  | Alive Dead |  |
| **Daughters** | Alive Dead |  |
|  | Alive Dead |  |
|  | Alive Dead |  |

**Physician Signature** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
**Date** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Please list drug and food allergies, along with adverse reactions:** ◊ None

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Please list any medication prescribed by a physician, any over-the-counter (non-prescription) medications, as well as any vitamin/mineral/nutritional supplements that you take on regular basis. Use extra sheet of paper if necessary.

**Medication Dose Frequency (times per day) Started Stopped**

Example: Lasix 20mg 1 pill 2 times a day 6/1/05 ……….

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**Which of the following conditions are you currently being treated or have been treated for in the past (please check)?**

◊ Anemia ◊ Gout ◊ Lupus ◊ Seizures

◊ Arthritis (age related) ◊ Heart disease / Angina ◊ Migraines ◊ Sinus problems

◊ Asthma ◊ Heart failure ◊ Neuropathy ◊ Sleep apnea

◊ Atrial fibrillation ◊ High blood pressure ◊ Osteoporosis ◊ Stomach ulcers

◊ Blood clots ◊ High cholesterol ◊ Peripheral vascular disease ◊ Stroke

◊ Cancer (list type) ◊ Kidney problems ◊ Pre-eclampsia ◊ Thyroid problems

◊ Diabetes ◊ Kidney stones ◊ Prostate Cancer ◊ Toxemia of pregnancy

◊ Dialysis ◊ Liver problems / Hepatitis ◊ Prostate enlargement ◊ Urine / bladder infections

◊ Emphysema / COPD ◊ Lung problems ◊ Rheumatoid arthritis

**Please describe any current or past medical treatments not listed above:**

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

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**Previous Operations Date Age Reason Complications?**

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

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**Have you used any of the following medications in the past on a daily basis (please check)?**

◊ Acetaminophen ◊ Bextra ◊ Fenoprofen ◊ Lodine ◊ Orudis ◊ Sulindac

◊ Advil ◊ Celebrex ◊ Flurbiprofen ◊ Meloxicam ◊ Oruvail ◊ Toradol

◊ Aleve ◊ Celecoxib ◊ Ibuprofen ◊ Mobic ◊ Oxaprozin ◊ Tylenol

◊ Anaprox ◊ Daypro ◊ Indocin ◊ Motrin ◊ Piroxicam ◊ Valdecoxib

◊ Ansaid ◊ Diclofenac ◊ Indomethacin ◊ Nabumetone ◊ Relafen ◊ Vioxx

◊ Arthrotec ◊ Etodolac ◊ Ketoprofen ◊ Naprosyn ◊ Rofecoxib ◊ Voltaren

◊ Aspirin ◊ Feldene ◊ Ketorolac ◊ Naproxen ◊ Salsalate

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**Review of Symptoms (please circle response)**

**Constitutional**

General good health No Yes

Recent weight loss

(# lbs\_\_\_\_\_\_) No Yes

Recent weight gain

(# lbs\_\_\_\_\_\_) No Yes

Fever No Yes

Chills No Yes Sweats No Yes Fatigue No Yes

Loss of energy No Yes

**Head**

Headaches No Yes

Migraines No Yes

Dizziness No Yes

Neck stiffness No Yes

Jaw pain No Yes

Hair loss No Yes

**Eyes**

Dry eyes No Yes

Light sensitivity No Yes

Double vision No Yes

Wear glasses No Yes

Date of last eye exam: \_\_\_\_\_\_\_\_\_\_\_\_

Surgeries: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Laser surgeries: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Ears**

Hearing loss No Yes

Hearing aids No Yes

Feeling of fullness in ears No Yes

Recurrent infections No Yes

Vertigo No Yes

**Nose**

Runny nose No Yes

Nasal stuffiness No Yes

Recurrent sinus infections No Yes

Postnasal drip No Yes

Nasal polyps No Yes

Nosebleeds No Yes

Snoring No Yes

Surgeries: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Throat / Mouth**

Frequent sore throats No Yes

Dry mouth No Yes

Metallic taste No Yes

Abnormal taste No Yes

Sores in mouth No Yes

**Cardiovascular**

Heart trouble No Yes

Chest pain / angina No Yes

Chest pressure No Yes

Palpitations No Yes

Racing heart No Yes

Short of breath lying flat No Yes

Ankle / leg swelling No Yes

Ulcers of feet / legs No Yes

Leg pain when walking No Yes

**Pulmonary**

Chronic or frequent cough No Yes

Sputum Production No Yes

Coughing up blood No Yes

Shortness of breath No Yes

Asthma / wheezing No Yes

**Gastrointestinal**

Loss of appetite No Yes

Change in taste sensation No Yes

Difficulty swallowing No Yes

Nausea / vomiting No Yes

Heartburn No Yes

Abdominal pain No Yes

Change in bowel habits No Yes

Constipation No Yes

Diarrhea No Yes

Blood in stool No Yes

Dark or tarry stool No Yes

**Genitourinary**

Urinate a lot No Yes

Inability to hold urine No Yes

Hesitancy during urination No Yes

Slow stream No Yes

Dribbling No Yes

Frequent urination No Yes

Burning upon urination No Yes

Frequent night urination No Yes

Blood in urine No Yes

Repeated urine infections No Yes

Kidney stones No Yes

Kidney infections No Yes

Excessive thirst No Yes

Excessive volume of urine No Yes

Foamy or frothy urine No Yes

Protein in urine No Yes

**Musculoskeletal**

Joint pain No Yes

Joint stiffness No Yes

Joint swelling No Yes

Joint redness No Yes

Muscle loss (atrophy) No Yes

Sciatica No Yes

Weakness of muscles/joints No Yes

Bone pain No Yes

Difficulty walking No Yes

Color change in fingers No Yes

Color change in hands No Yes

Color change in feet No Yes

**Neurological**

Frequent headaches No Yes

Lightheaded or dizzy No Yes

Convulsions or seizures No Yes

Excessive sleepiness No Yes

Restless legs No Yes

Numbness or tingling No Yes

Tremors No Yes

Paralysis No Yes

**Endocrine**

Thyroid disease No Yes

Heat intolerance No Yes

Cold intolerance No Yes

Hair loss No Yes

**Skin**

Hives No Yes

Eczema No Yes

Itching No Yes

Rashes No Yes

Lumps No Yes

Nail changes No Yes

Acne No Yes

Increased hair growth No Yes

Increased skin pigment No Yes

**Psychiatric**

Memory loss or confusion No Yes

Nervousness / anxiety No Yes

Insomnia No Yes

Depression No Yes

**Hematological**

Blood clot No Yes

Easy bleeding No Yes

Easy bruising No Yes

Frequent bruising No Yes

Prolonged bleeding No Yes

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**STAMPER OR PATIENT LABEL**

**Authorization to Disclose Health Information to Family or Other**

Patient’s Name: Date of Birth:

Street Address:

City: State: Zip:

I hereby authorize Cheyenne Regional Medical Center to disclose health information to the following contact(s):

**Contact #1**

Name: Relationship to me:

Home Phone: Alternate Phone:

**Contact #2**

Name: Relationship to me:

Home Phone: Alternate Phone: \_\_\_\_\_\_

The information that may be disclosed or discussed is related to: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_,

(e.g. current treatment, related to incident)

for the purpose of: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, and may include the following:

🞏 Treatment and Progress Notes 🞏 Nursing Records

🞏 Treatment Plans 🞏 Lab(s)

🞏 Financial Records 🞏 Medications

🞏 Other (Please Specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Once your health information has been disclosed, re-disclosure of your health information by the recipient may no longer be protected by law. You may revoke this authorization in writing at any time. Please note that cancellation by telephone must be confirmed in writing. Your revocation will not affect any disclosure made under this authorization prior to your revocation.

I understand that authorizing the disclosure of this health information is voluntary and I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

By signing this form I understand that Cheyenne Regional Medical Center may discuss past, present, or future health care issues with the above named contacts from \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ through\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Start End (not more than 1 year from the date of this authorization)

Signature: Date:

If Personal Representative Signed:

Personal Representative Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relation to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Page 1 of 1

ROI

\*ROI\*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name: (Last, First MI)  *Preferred Name:* | | Sex (M/F) | Birth Date: | |
| Mailing Address: | | | Social Security #: | |
| City, State, Zip: | | | Primary Care Provider: | |
| Phone Numbers: *Check Which Number is Preferred*  HOME # MOBILE # WORK #  \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Referring Provider: | |
| Email: | |
| *Emergency Contact Name:* | *Contact Relationship:* | | *Emergency Contact Phone:* | |
| **Check next to the box that applies:**  *These questions are used for hospital survey purposes*  **Marital Status: Ethnicity: Race:**  Married Hispanic/Latino American Indian or Alaskan Native  Single Not Hispanic or Latino Asian  Divorced Unknown Black or African American  Widowed More than One Race  Separated Native Hawaiian  Partner Pacific Islander  Other White/Caucasian  Other | | | | **Primary Language:**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Preference of Religion:**  **U.S State of Birth:**  If *OTHER* please check box |
| ***How did you hear about us?*** |
| **Employer:** | | | | Full Time Student N/A  Part Time Retired |

|  |  |  |  |
| --- | --- | --- | --- |
| **Guarantor/Responsible Party**: If ***SELF*** (Same as above info Check Box) *If different, please fill out below:* | | | |
| Relationship to Patient: | Best Phone Number: | | |
| Name: (Last, First, Middle) | | Sex (M/F) | Birth Date: |
| Mailing Address: | | City, State, Zip: | |

|  |  |  |  |
| --- | --- | --- | --- |
| **INSURANCE:** *If you are going through Workers Compensation skip to the last section* | | | |
| **PRIMARY INSURANCE COVERAGE:** | | **SECONDARY INSURANCE COVERAGE:** | |
| *Policy Holder Name:* | *Relationship to Patient:* | *Policy Holder Name:* | *Relationship to Patient:* |
| *Policy #* | *Group #* | *Policy #* | *Group #* |
| *Insurance Start Date:* | | *Insurance Start Date:* | |
| ***WORKERS COMPENSATION CLAIM # Date of Injury:*** | | | |



2301 House Ave., Suite 201 • Cheyenne, WY 82001 • (307) 638-7757 • cheyenneregional.org

**CANCELLATION AND MISSED APPOINTMENT/NO SHOW PROCEDURE**

Dear Valued Patient,

Our goal is to provide timely quality medical care. No-Shows and late cancellations inconvenience those who need access to medical care in a timely manner. This policy enables us to better utilize available appointments for all of our patients.

**CANCELLATION OF AN APPOINTMENT**

In order to be respectful of the medical needs of other patients, please be courteous and call the Medical Specialty Clinic promptly if you are unable to show up for an appointment. If it is necessary to cancel your scheduled appointment, we require that you call at least 24 hours in advance. Appointments are in high demand and your early cancellation will give another person the possibility to have access to timely medical care.

**HOW TO CANCEL YOUR APPOINTMENT**

To cancel an appointment, please call (307) 638-7757. If you do not reach the receptionist you may leave a detailed message on our voicemail. Please leave your name and phone number and we will return your call to give you the next available appointment time.

**LATE CANCELLATION**

A late cancellation is someone who does not cancel their appointment before 24 hours of their scheduled appointment time.

**NO-SHOW PROCEDURE**

A “no-show” is someone who fails to arrive for a scheduled appointment without cancelling the appointment prior to the scheduled time.

* First no show: There will be no charge
* Second no show: May result in a $25 fee billed to your account
* Third no show: May result in an additional $25 fee billed to your account and dismissal from our practice.

***I have read and understand the Medical Specialty Clinic Cancellation and Missed Appointment/No Show Procedure.***

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Patient Printed Name Date of Birth

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

Patient Signature Today’s Date

***The Medical Specialty Clinic values you as a patient and strives to provide you with excellent medical services! Thank you for your support of this process****.*