



Cheyenne Regional
Medical Group
Medical Specialty Clinic

Nephrology

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

Patient Name _____ Date: _____

Provider you will be seeing: _____

PLEASE ARRIVE AT _____ FOR YOUR CHECK IN TIME

Appointment Date: _____

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 **AT YOUR CHECK IN TIME** 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 _____

Is there a family history of:

Kidney Disease?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Kidney Stones?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Dialysis?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
High blood pressure?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
High cholesterol?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Heart disease?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Diabetes?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Cancer?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Stroke?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Anemia?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Hearing Loss?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Lupus?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____

List Relative (s)

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

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	

Preventative Services & Dates:

Colonoscopy _____

Mammogram _____

Rectal Exam _____

Physician Signature _____

Date _____

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

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.

<u>Medication</u>	<u>Dose</u>	<u>Frequency (times per day)</u>	<u>Started</u>	<u>Stopped</u>
Example: Lasix	20mg	1 pill 2 times a day	6/1/05
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

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

- ◇ Anemia
- ◇ Arthritis (age related)
- ◇ Asthma
- ◇ Atrial fibrillation
- ◇ Blood clots
- ◇ Cancer (list type)
- ◇ Diabetes
- ◇ Dialysis
- ◇ Emphysema / COPD
- ◇ Gout
- ◇ Heart disease / Angina
- ◇ Heart failure
- ◇ High blood pressure
- ◇ High cholesterol
- ◇ Kidney problems
- ◇ Kidney stones
- ◇ Liver problems / Hepatitis
- ◇ Lung problems
- ◇ Lupus
- ◇ Migraines
- ◇ Neuropathy
- ◇ Osteoporosis
- ◇ Peripheral vascular disease
- ◇ Pre-eclampsia
- ◇ Prostate Cancer
- ◇ Prostate enlargement
- ◇ Rheumatoid arthritis
- ◇ Seizures
- ◇ Sinus problems
- ◇ Sleep apnea
- ◇ Stomach ulcers
- ◇ Stroke
- ◇ Thyroid problems
- ◇ Toxemia of pregnancy
- ◇ Urine / bladder infections

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

<u>Previous Operations</u>	<u>Date</u>	<u>Age</u>	<u>Reason</u>	<u>Complications?</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

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

- ◇ Acetaminophen
- ◇ Advil
- ◇ Aleve
- ◇ Anaprox
- ◇ Ansaïd
- ◇ Arthrotec
- ◇ Aspirin
- ◇ Bextra
- ◇ Celebrex
- ◇ Celecoxib
- ◇ Daypro
- ◇ Diclofenac
- ◇ Etodolac
- ◇ Feldene
- ◇ Fenoprofen
- ◇ Flurbiprofen
- ◇ Ibuprofen
- ◇ Indocin
- ◇ Indomethacin
- ◇ Ketoprofen
- ◇ Ketorolac
- ◇ Lodine
- ◇ Meloxicam
- ◇ Mobic
- ◇ Motrin
- ◇ Nabumetone
- ◇ Naprosyn
- ◇ Naproxen
- ◇ Orudis
- ◇ Oruvail
- ◇ Oxaprozin
- ◇ Piroxicam
- ◇ Relafen
- ◇ Rofecoxib
- ◇ Salsalate
- ◇ Sulindac
- ◇ Toradol
- ◇ Tylenol
- ◇ Valdecoxib
- ◇ Vioxx
- ◇ Voltaren

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



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 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.

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***