

# Georgia Kidney Associates

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## Patient Information Sheet

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Referred By: \_\_\_\_\_

**Instructions:** Please provide the information requested below as completely as possible. This information will be used to assist us in providing you with the best medical care possible. The form will be reviewed by the doctor, and you will then be asked for additional information during your visit.

What problems brought you to see the doctor today?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**FAMILY HISTORY:** Have any of your relatives had any of the following diseases? If so, please indicate which relative(s) was (were) affected:

Disease	Family Member(s)
Diabetes	
High Blood Pressure	
Heart Attack	
Other Heart Disease	
Stroke	
Cancer	
Kidney Failure	
Arthritis	
Lupus or Similar Disease	
Deafness	
Bleeding Problems	
Inherited Disease	

Father: Living Yes  No  Health Status: \_\_\_\_\_  
 Cause of Death: \_\_\_\_\_

Mother: Living Yes  No  Health Status: \_\_\_\_\_  
 Cause of Death: \_\_\_\_\_

Brothers: Number Living ( ) Number Deceased ( )

Sisters: Number Living ( ) Number Deceased ( )



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## REVIEW OF SYSTEMS

Please answer Yes or No to each question and provide an explanation of **each** affirmative answer.

General	Yes	No	Explanation
Change in appetite			
Change in weight			
Anemia			
Bleeding Problem			
History of Cancer			

Endocrine	Yes	No	Explanation
Diabetes			
Thyroid Disease			
Cortisone Use			

ENT	Yes	No	Explanation
Glasses			
Changing Vision			
Deafness			
Sinus problems			
Swallowing problem			
Other			

Pulmonary	Yes	No	Explanation
Cigarette use			
Cough up Blood			
Chronic Cough			
Asthma			
Pneumonia			
Emphysema			
Chronic Bronchitis			
Shortness of Breath			
Other			

Cardiovascular	Yes	No	Explanation
Rheumatic Fever			
Heart Murmur			
Chest Discomfort			
Chest Pain			
Heart Attack			
Irregular Pulse			
Palpitations			
Shortness of Breath			
Swelling			
High Blood Pressure			
Heart Failure			
Fainting			
Blood Clots			
Abnormal EKG			
Cardiac Catheter			
Exercise Test			
Other			

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## REVIEW OF SYSTEMS (CONT'D)

<b>Gastrointestinal</b>	<b>Yes</b>	<b>No</b>	<b>Explanation</b>
Hepatitis			
Jaundice			
Blood in Stools			
Nausea/Vomiting			
Ulcers			
Vomiting Blood			
Chronic Diarrhea			
Constipation			
Cancer			
Other			

<b>Renal and GU</b>	<b>Yes</b>	<b>No</b>	<b>Explanation</b>
Kidney Stones			
Bright's Disease			
Blood in Urine			
Kidney Failure			
Voiding Difficulty			
Bladder Surgery			
Bladder Infections			
Kidney Infections			
Prostate Disease			
Other			

<b>Musculoskeletal</b>	<b>Yes</b>	<b>No</b>	<b>Explanation</b>
Joint Pain			
Joint Swelling/Head			
Deformed Joints			
Broken Bones			
Skin Rash			
Skin Cancer			
Hair Loss/Gain			
Nail Problems			
Other			

<b>Neurologic</b>	<b>Yes</b>	<b>No</b>	<b>Explanation</b>
Seizures			
Stroke			
Headaches			
Change in Vision			
Dizziness			
Fainting			
Tremor/Shakes			
Trouble Walking			
Psychiatric Problem			
Other			

