Carolina Kidney & Hypertension Center, LLC Health Questionnaire

Family Medical History

Relation	Age	State of Health	Age at Death	Cause of Death	Check ($$) if blood relatives have the following	Relationship
Father					Hypertension	
Mother					Kidney Disease	
Siblings					Heart Disease	
					Cancer	
					Arthritis	
					Gout	
					Diabetes	
					Asthma	

<u>Hospitalizations</u> (including pregnancies and Operations)

Year	Hospital	1	Reason for Hospitalization
Allergies		Habits ($\sqrt{\ }$) which substantiates	nces you use and indicate how much
(Please list))		
		Tobacco	Alcohol
		Caffeine (Coffee)	Other Drugs

Carolina Kidney & Hypertension Center, LLC Health Questionnaire

Name:						
Symptoms (Ple	ease (√)	all that apply)			
General Gastrointestina Fever Anorexia			Cardiovascular Chest Pain		Genito-Urinary Painful Urination	Muscle/Bone/Joint Joint Swelling
Chills Nausea		ea	Palpitations		Poor Urine Stream	Muscle weakness
Sweats Vomiting		ting	Rapid Heart Beat		Incontinence	Others List
Insomnia Loose Stools Leg Swelling Blood in Stoo		Stools	Shortne	ess of Breath	Frequent Urination	
		in Stool	Ortho	pnea	Blood in Urine	
Weight Loss Consti		ipation Fatig		e	Foamy Urine	
	Dizziness		Reflux	ζ.		
Health Conditi	ions (P	lease ($$) all th	at apply)			
AIDS (HIV disease)		Anemia		Arthritis	Asthma	Anorexia
Bleeding disorders		Bronchitis		Cancer	COPD (emphysema) Cataracts
Diabetes		Epilepsy		Glaucoma	Gioter	Gout
Hepatitis		Heart disease		Hives	Headaches	High BP
High-Cholesterol		Jaundice		Kidney Stones		Kidney Infections
ÎIncontinence		Kidney Failure		Prostate Problems		Stroke
Organ Transplant		Thyroid disease		TB	List Others	
List of Medica	<u>tions</u>					

Carolina Kidney & Hypertension Center, LLC Patient Registration Form

Patient name	Social Security Number		
Date of Birth	Address		
Marital Status	Email address		
Home phone	Work phone or Cell phone		
Emergency contact (Name)	Emergency contact (Phone number)		
Employer			
Insurance company name and policy number	Insurance company name and policy number/		
Primary	Secondary		
If you are covered under the policy of a spouse, page 1	artner, parent, or legal guardian, please tell us about them:		
Name	Social Security Number		
Date of Birth	Address		
Home phone	Work phone		
Mobile phone or pager	Email address		

Consent to Treat:

I (or my legal guardian or parent) authorizes Carolina Kidney & Hypertension Center to provide medical care to me.

Assignment of Benefits:

I understand that I am financially responsible for all charges

I hereby authorize the release of information necessary to secure the payment of benefits, and assign any insurance or other third-party benefits for health care services received to <u>Carolina Kidney & Hypertension Center</u>. If these benefits are not assigned to <u>Carolina Kidney & Hypertension Center</u>, I agree to forward to Carolina Kidney & Hypertension Center all benefits immediately upon receipt.

I have read and understand the information outlined above		
Signature of Patient/Legal Guardian:	Date:	Created on 8/26/2004 : Modified 10/7/