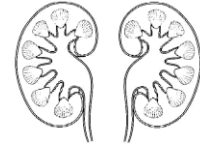




# KIDNEY SPECIALISTS, PLLC



1004 Sushruta Drive, Suite A  
Martinsburg, WV 25401  
Phone (304) 449-3778 Fax (304) 449-3777

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

**Address:** \_\_\_\_\_

\_\_\_\_\_

**Home Phone:** \_\_\_\_\_ **Cell Phone:** \_\_\_\_\_

**Work Phone:** \_\_\_\_\_ **Email:** \_\_\_\_\_

**Gender:** Male Female **Age:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Social Security Number:** \_\_\_\_\_

**Marital Status:** Single Married Divorced Widowed

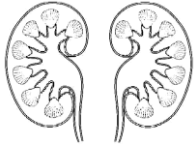
**Occupation:** \_\_\_\_\_

**Referred By:** \_\_\_\_\_ **Primary Care Doctor:** \_\_\_\_\_

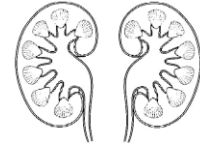
**Pharmacy Name and Address:** \_\_\_\_\_

## **PAST MEDICAL HISTORY:**

Condition	Circle One	Additional Details
Kidney Disease	YES / NO	
Congestive heart failure	YES / NO	
Heart disease/Heart attack	YES / NO	
Heart procedures/interventions	YES / NO	
Diabetes Type 1	YES / NO	
Diabetes Type 2	YES / NO	
Hepatitis	YES / NO	
Liver cirrhosis	YES / NO	
Cancer (What kind?)	YES / NO	
High blood pressure	YES / NO	
Kidney stones	YES / NO	
Stroke	YES / NO	
Ministroke (TIA)	YES / NO	
Seizure disorder	YES / NO	
Diabetic eye changes (retinopathy)	YES / NO	
Bipolar disorder	YES / NO	
Asthma	YES / NO	
COPD/Emphysema	YES / NO	
Sleep apnea	YES / NO	



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Gout	YES / NO	
Peripheral vascular disease	YES / NO	
HIV	YES / NO	
Lupus	YES / NO	
Prostate enlargement	YES / NO	
Anemia	YES / NO	
Other medical problems	YES / NO	

## **PAST SURGERIES:**

## **ALLERGIES** (LIST ALL DRUG ALLERGIES):

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## **FAMILY HISTORY:** (Please Check ALL That Apply to Any of Your Blood Relatives)

- Kidney Disease     Cancer (what kind? \_\_\_\_\_)
- Diabetes     Heart Disease     Kidney Stones     high blood pressure

## **SOCIAL HISTORY**

Tobacco use?  never     quit \_\_\_\_ years ago     yes (  cigarettes     cigars     pipe     chew tobacco)

Drink alcohol?     Daily     Weekly     Occasionally     Never

Do you currently use intravenous drugs?     YES     NO

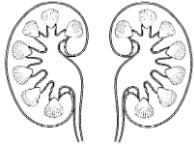
Have you ever used intravenous drugs?  YES  NO                      Most recent intravenous drug use?

Have you ever shared needles?  YES  NO

## **EMERGENCY CONTACT'S INFORMATION:**

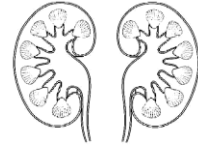
Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone Number: \_\_\_\_\_



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Name of the Medication	Dose	Frequency

**Practice Locations:**

1004 Sushruta Drive  
Suite A  
**Martinsburg WV 25401**  
Phone (304) 499-2778

480 W. Jubal Early Drive  
Suite 200  
**Winchester VA 22601**  
Phone (540) 313-6563

821 S. King Street  
Suite L  
**Leesburg VA 20175**  
Phone (703) 722-1500

I certify, to the best of my knowledge, all information listed above is true. I further certify that I have not misstated or intentionally omitted any information related to my health or past medial history.

Date: \_\_\_\_\_ SIGNATURE of patient/guardian: \_\_\_\_\_