Plaza 3
1315 South Cliff Avenue, Suite 2000
Sioux Falls, SD 57105
(605) 322-5800 • Fax (605) 322-5801

Name: ______________________________

Date of Birth: ______________________________

Why did you come to Avera Medical Group Nephrology today? ______________________________

____

How old are you? __________ years How tall are you? ________feet ________inches

Please list any medication allergies and what happens when taken:

Medication: ____________________ What happens: ____________________

Medication: ____________________ What happens: ____________________

Medication: ____________________ What happens: ____________________

Medication: ____________________ What happens: ____________________

What medications do you take? Please provide the dose and frequency:

____________________	____________________
____________________	____________________
____________________	____________________
____________________	____________________
____________________	____________________
____________________	____________________
____________________	____________________
____________________	____________________
____________________	____________________

What medical problems, diseases or diagnoses do you have?	Date of onset:
______________________________	__________
______________________________	__________
______________________________	__________
______________________________	__________
______________________________	__________
______________________________	__________
______________________________	__________
______________________________	__________
______________________________	__________
______________________________	__________

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Name: ______________________________

Date of Birth: ______________________________

Who is your primary care doctor:______________________________

What is your family history of medical problems or diseases?

Father:______________________________

Mother: ______________________________

Brothers & Sisters: ______________________________

____

____

____

____

Is there kidney disease in your family? ______________________________

Is there diabetes in your family? ______________________________

Is there cancer in your family?______________________________

Is there heart disease in your family? ______________________________

How much do you smoke? ______________________________

How much alcohol do you drink?______________________________

Have you ever had hepatitis or yellow jaundice? ______Yes ______No

Have you seen blood in your urine? ______Yes ______No

Have you seen blood in your stool? ______Yes ______No

When was your last Influenza vaccination?______________________________

Have you received the Pneumovax (sometimes called the "pneumonia vaccine")? ______Yes ______No

If yes, when? ______________________________

When was your last Tetanus shot? ______________________________

If you have Medicare coverage, do you have an Advanced Care Plan (Living Will)?

______Yes ______No ______Unknown

Date:______________ Time:______________ Signature of Patient:______________________________