South Florida Nephrology Consultants

Memorial Regional Hospital Medical Office Centre
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Julio C. Vijil, M.D. **Neil J. Weiner, D.O.**
Board Certified, American Board of Internal Medicine
Board Certified, American Board of Nephrology
Beth L. Fromkin, M.D.
Board Certified, American Board of Internal Medicine

Name:_________________________

Age: _______

Gender: ______________

Allergies

1___________________________

2___________________________

3___________________________

Reaction

1___________________________

2___________________________

3___________________________

Medical History

__Hypertension. # of Years _____

__Diabetes. # of Years _____

Has it affected your eyes?

__Yes __No __Unsure

When was your last eye exam?

Date________________

__Congestive Heart Failure

__Heart Disease

Stent: __Yes __No

__Stroke

__Cancer

Type:

__Peripheral Vascular Disease

__Thyroid Problem

__Kidney Problem

__Kidney Stone

__Lung Problem

__Circulation Problem

__High Cholesterol

Any Other Important Conditions?

1___________________________

2___________________________

3___________________________

Surgical History

Surgery	Year
1___________________________	1 ___________________________
2___________________________	2 ___________________________
3___________________________	3 ___________________________

Hospitalization (within 1 year)

List reason and year

1___________________________ ___________________________

2___________________________ ___________________________

3___________________________ ___________________________

Family History (Check all that apply)

Father: __Alive __Deceased	***Mother***: __Alive __Deceased
__Kidney Problem	__Kidney Problem
__Diabetes	__Diabetes
__High Blood Pressure	__High Blood Pressure
__Heart Disease	__Heart Disease
__Stroke	__Stroke
__Cancer	__Cancer
__Unknown	__Unknown
Siblings: __Alive __Deceased	***Children***: __Son __Daughter
# of Brothers:___ # of Sisters:___	# of Sons:___ # of Daughters:___

Immunizations

__Influenza vaccine (flu shot)

Received this past year: Yes No

If no, why was the vaccine not received?

Social History (check all that apply)

Marital Status: Married Single Divorced Widowed

Travel: Yes No

Smoking: Yes No

If yes: Current Former

Packs per day:____ # of Years:_______

If you quit, how long ago? _____

Caffeine: Yes No

Alcohol: Yes No

Drugs (recreational): Yes No

Http://www.southfloridanephrology.com

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Review of Systems

Name:________________________

What do you use for everyday pain?

Advil __Tylenol __Motrin __Aleve __Naproxen

Are you taking over the counter Meds

Yes __No

If yes, please list below

1_

2_

3_

Check All That Apply

Dermatology

__Rash
__Itching

Endocrinology

__Fatigue
__Excessive sweating
__Excessive Thirst

General

__Weight change
__Loss of appetite
__Fever
__Weakness

Ophthalmology

__Diminished Vision
__Eye irritation
__Drainage from eyes
__Blurring of vision

Neurology

__Headache
__Numbness
__Seizures

ENT/Respiratory

__Coughing up blood
__Nose bleed
__Hearing Loss
__Sore Throat
__ Cough

Cardiology

__Chest pain
__Palpitations
__Leg Swelling
__Dizziness
__Shortness of breath
__Waking up short of breath

Gastroenterology

__Nausea
__Black tarry stools
__Difficulty Swallowing
__Abdominal pain
__Diarrhea
__Constipation
__Blood in stool

Musculoskeletal

__Joint Swelling
__Joint Pain
__Leg Cramps
__Joint Stiffness
__Pain in upper back
__Muscle Aches

Psychology

__Depression
__Anxiety
__Sleep problems

Genitourinary Male

__Urinary urgency
__Difficulty urinating
__Blood in urine
__Prostate disease
__Urinating at night
# of times________
__Proteinuria

Genitourinary Female

__Blood in urine
__Difficulty urinating
__Urinary urgency
__Urinating at night
# of times________
__Proteinuria