Dear Patient,

We are delighted to welcome you to our kidney and hypertension practice. We want you to know that we appreciate the opportunity to participate in your medical care. Our doctors and staff are focused on providing high quality, personal care. We look forward to building a relationship with you.

Enclosed you will find both a medication list and a health history form. Having this completed as accurately as possible prior to your first appointment is important. We appreciate you taking the time to do so. You can expect that your initial consultation will take approximately one hour. The doctor will need a urine sample from you as well.

As a courtesy, our office staff will gladly submit your claims to your insurance company. Please bring in the most current insurance card along with any applicable claim forms. We will verify coverage during your visit so please be prepared to pay your co-payment at that time. If you do not have medical insurance, please notify a member of our office staff and we will be happy to discuss payment options with you.

Also included in this packet is a map to the location we agreed upon. If you receive a map to a different location than agreed upon, please call our office and verify which location your appointment is actually scheduled in. If you have any further questions please do not hesitate to call us at (208) 846-8335.

Thank you again for allowing us to serve you. We look forward to meeting you.

Sincerely,

Boise Kidney & Hypertension Institute
New Patient Information

Please fill out this information prior to your visit with the doctor. Thank you!

Patient Name: ___________________________________ DOB: ____________________

*Please indicate if you have experienced any of the following:

**Pulmonary:**
☐ Shortness of breath
☐ Frequent cough
☐ Coughing up blood
☐ Wake up at night, short of breath
☐ Wheezing

**Cardiac:**
☐ High blood pressure
☐ Heart attack
☐ Leg swelling
☐ Shortness of breath w/ exercise
☐ Chest pain
☐ Heart racing or thumping
☐ Need to sleep on more than 2 pillows
☐ High cholesterol

**Musculoskeletal:**
☐ Muscle weakness
☐ Joint pain
☐ Joint swelling

**Dermatological:**
☐ Rash

**Neurological:**
☐ Numbness or tingling
☐ Imbalance or unsteadiness
☐ Dizziness

**Gastrointestinal:**
☐ Abdominal pain
☐ Nausea
☐ Vomiting
☐ Diarrhea

**Hematologic/Oncologic:**
☐ Anemia
☐ Bleeding tendency
☐ Blood clot in legs or lungs

**Renal:**
☐ Difficulty emptying bladder
☐ Blood in urine
☐ Protein in urine
☐ Urinary tract infections
☐ Kidney stones
☐ Frequent urination at night
☐ Painful urination

**Eyes, Ears, Nose, Throat:**
☐ Blurred vision

**Endocrine:**
☐ Diabetes Mellitus
☐ Type I
☐ Type II
☐ Controlled
☐ Uncontrolled

**Psychiatric:**
☐ Anxiety
☐ Depression
☐ Poor sleep

**Constitutional:**
☐ Fever
☐ Weight gain
☐ Weight loss
☐ Chills

**Other:**
☐ ____________________
☐ ____________________
# Current Medication List

<table>
<thead>
<tr>
<th>Name of Medication</th>
<th>Dosage</th>
<th>How often do you take it?</th>
<th>Date Started</th>
<th>Prescribing Doctor</th>
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**Patient Name:** ____________________________  **Date of Birth:** ________________

**Patient Signature:** X ____________________________  **Date:** ________________
Patient Name: ___________________________ DOB: ___________________________

Please list current medical problems: __________________________________________

____________________________________

Please list past medical problems: __________________________________________

____________________________________

Please list any past surgeries: __________________________________________

____________________________________

Do you smoke now? _______ Did you ever smoke? _______ If yes, packs per day: _______ When did you quit? _______

Do you drink alcohol? _______ If yes, drinks per day _______ History of drug use? _______ If yes, which drug: _______

Do any of these medical conditions run in your family?

☐ Cancer: Grandparent ___ Mother ___ Father ___ Brother ___ Sister ___ Type: __________________________

☐ Heart Disease: Grandparent ___ Mother ___ Father ___ Brother ___ Sister ___

☐ Stroke: Grandparent ___ Mother ___ Father ___ Brother ___ Sister ___

☐ Kidney Disease: Grandparent ___ Mother ___ Father ___ Brother ___ Sister ___

☐ Dialysis: Grandparent ___ Mother ___ Father ___ Brother ___ Sister ___

☐ Diabetes: Grandparent ___ Mother ___ Father ___ Brother ___ Sister ___

☐ High blood pressure: Grandparent ___ Mother ___ Father ___ Brother ___ Sister ___

☐ Other Conditions: __________________________

Please list any food or drug allergies: __________________________________________

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<th>Reaction? (Ex: Rash, swelling, diarrhea, hives)</th>
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