DIALYSIS ACCESS SPECIALISTS OF THE CENTRAL VALLEY
6235 N. FRESNO STREET SUITE 106 FRESNO, CA 93710
559.475.0431

What to Bring to Your Appointment

Identification & Insurance

Be sure to bring your photo identification and medical insurance information. Your co-pay will be collected at the time of service.

Medications & Records

Please bring your current medication bottles. If requested, also bring medical records from your referring physician.

Patient Forms

Be sure to bring the requested patient forms, such as the Patient Information Form and Medical History Form.

What to expect for your first appointment:

- At your first visit to our office, your physician will review all medical records we received. Your physician will look specifically for information that relates to your medical needs—as well as any other pertinent health details.
- Your physician will review your current medications, allergies, kidney health history, past medical history, and any hospitalizations or surgeries. We will also want to discuss any current symptoms that you may be experiencing.
- Your physician will order any needed tests. Tests may include blood work and diagnostic procedures.

Prescription Refills

Monday -Thursday we will attempt a 48-72 hour turnaround. Request all refills direct from your pharmacy for the quickest results. Friday & weekend refills will be processed only for emergencies.

Medical Response Service

Please don't hesitate to contact us by phone, if we can assist you with any questions you may have. During business hours, please allow 48 hours for a response from our medical secretaries. If you have an emergency go directly to the emergency room. We are on call 24 hours a day, 7 days a week for emergencies.

Dialysis Access Specialists of the Central Valley

6235 N. Fresno Street, STE 106, FRESNO, CA 93710 PHONE: 559-475-0431 FAX: 559-475-0346

PATIENT INFORMATION

☐MR. ☐MRS. ☐MS. ☐MISS. ☐UNDISCLOSED SSN:_____ DATE FIRST SEEN: _____

NAME: _____DATE OF BIRTH: _____

ADDRESS: _____ _____ _____ _____
Street City State Zip Code

E-Mail: _____ Phone: _____

MARITAL STATUS: ☐ MARRIED ☐ SINGLE ☐ WIDOWED ☐ DIVORCED

INSURANCE INFORMATION: ☐MEDICARE ☐MEDICARE-SECONDARY ☐HMO PLAN ☐MEDI-CAL
☐PRIVATE ☐EMPLOYER GROUP INS PLAN ☐CHAMPUS

PRIMARY INSURANCE:	SECONDARY INSURANCE:
ADDRESS:	ADDRESS:
SUBSCRIBER:	SUBSCRIBER:
ID NO: GROUP NO:	ID NO: GROUP NO:
EFFECTIVE DATE:	EFFECTIVE DATE:

EMPLOYED: ☐YES STUDENT: ☐FULL-TIME ☐PART-TIME

PATIENT'S EMPLOYER:_____WORK PHONE #:_____

SPOUSE'S NAME:_____SPOUSE'S DATE OF BIRTH:_____

SPOUSE'S EMPLOYER:_____WORK PHONE #:_____

IF MINOR, LIVES WITH:_____RELATIONSHIP:_____

NEAREST RELATIVE/FRIEND:_____RELATIONSHIP:_____

ADDRESS:_____PHONE #:_____

PRIMARY CARE PHYSICIAN:_____

WHO REFERRED YOU TO THIS OFFICE?_____

ARE YOU A DISABLED INDIVIDUAL RECEIVING MEDICARE? ☐YES

IS ILLNESS RELATED TO… ☐EMPLOYMENT ☐AUTO ACCIDENT

Dialysis Access Specialists of the Central Valley

Name:_____

Communication:
Information obtained from: Patient, spouse, parent, child, other relative, friend other: _____ Phone Interview Can the patient speak English? N Y Primary language spoken?_____
Can the patient read English? N Y Primary language written? _____
Do you need an interpreter? N Y

PMH: Past Medical History Of

_____ High Cholesterol
_____ High Blood Pressure
_____ Heart Attack(s)
_____ Angina
_____ Irregular Heart Beat
_____ Heart Murmur
_____ Rheumatic Fever
_____ Congestive Heart Fail.
_____ Blood clots to lung/legs
_____ Stroke(s)
_____ Diabetes
_____ Asthma
_____ Emphysema/COPD
_____ Pneumonia
_____ Kidney Stones
_____ Kidney Infection
_____ Ulcers of Stomach
_____ Diverticulosis
_____ Hiatal Hernia
_____ Liver Disease
_____ Hepatitis
_____ Anemia
_____ Radiation Therapy
_____ Chemotherapy
_____ Cancer or Leukemia
_____ Alzheimer's or Dementia
_____ Seizures
_____ Low back pain problems
_____ Immune deficiency
_____ Glaucoma
_____ Infectious Process
_____ Renal Failure
_____ Thyroid
_____ Arthritis
_____ Prostate Problems
_____ Ovary/Uterus Prob.
_____ Dialysis
_____ Chronic Pain
_____ Sleep Apnea
_____ Diabetic Retina Dis.

SxHx : Has patient had Surgeries or procedures? Indicate year if able; otherwise use a check/circle

_____ Open Heart
_____ Angioplasty-Balloon
_____ Artery Surgery
_____ Ostomy
Type:
_____ Gall Bladder
_____ Appendix
_____ Bowel Blockage
_____ Stomach
_____ Hip Repair
_____ Ankle or Knee
_____ Back or Neck
_____ Mouth
_____ Kidney Stone Removal
_____ Cataracts/eyes/laser surgery
_____ Ears or tonsils
_____ Tubes tied
_____ Uterus or Ovaries
_____ Pacemaker
_____ Implanted Defibrillator
_____ IV Device
_____ VP Shunt

PSFH: Family History of

Hypertension Diabetes Cancer

Personal History

Alcohol use Cigarettes Illicit drugs

Social History

Married Widowed Occupation Living Situation

ROS: Recent Symptoms

General

1. Weight change: amt. _____
   Time Frame _____
2. Fever/Chills or Sweats
3. Tired all the time
4. Loss of appetite
   Time Frame _____
5. Poor Appetite
   Time Frame _____

Head & Neck

Headaches-
What pain medication is used?
How often?
How long has med been taken?

Eyes

6. Worsening vision
7. Eye discharge
8. Temporary loss of vision

Ears, Nose Mouth and Throat

9. Ringing in the ears
10. Nosebleeds
11. Runny or stuffy nose
12. Sore throat
13. Difficulty swallowing
14. Hoarse voice

Respiratory

15. Short of breath at rest
16. Short of breath on exertion
17. Cough
18. Wheezing
19. Phlegm
10. Major Pulmonary infection
    Pneumonia
    Bronchitis

Cardiovascular

21. Chest pains or pressure
22. Racing heart
23. Irregular heart beats
24. Wake up short of breath
25. Need 2+ pillows at night
26. Leg cramps from walking
27. Swelling of extremities
28. Fatigue
29. Dizziness

Chest (Breasts)

30. Breast lump
30. Discharge

Gastrointestinal

32. Heart Burn
33. Stomach pains
34. Nausea
35. Vomiting
36. Vomiting blood
37. Difficulty swallowing

Change in Bowel Movement

39. Black color
40. Bloody
41. Diarrhea
42. Constipation

Genitourinary

46. Painful urination
47. Frequent urination
48. # or times you urinate at night
49. Hard to urinate
50. Blood in urine

Hematologic/Lymphatic

57. Bleed easily
58. Bruise easily
59. Swollen glands

Blood/Transfusion Information

60. Previous blood transfusion
61. Designated donor

Musculoskeletal

63. Joint/Muscle swelling or pain
64. Back or neck pain
65. Leg swelling
66. Unable to walk on own
67. Type of device needed

_____

68. Bed ridden

How long: _____
What pain medication is used?
How often?
How long has med been taken?

Skin

69. Rash
70. Sores or wounds
71. Itchy

Skin Cancer

Neurologic

72. Convulsions/seizures
73. Passing out
74. Headaches
75. Loss of memory
76. Numbness/tingling

Psychiatric

77. Depressed feelings
78. Anxious or panic feelings
79. Can't sleep due to worries

Endocrine

80. Hair or skin change
81. Thirsty often
82. Weight change
83. Energy change

No thyroid or any other endocrinopathy
On Thyroid Medications?
How long?
Medication Allergies?

Allergy/Immune

84. Hives
85. Sneezing
86. Sweats and chills
87. Recent steroid use
88. Other

_____
_____
_____
_____