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:



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:**--------------------------

## I PMH: Past Medical History Of

y

Do you need an interpreter? N

Primary language written? \_

Y

Primary language spoken? \_

Y N

the patient speak English? N Can the patient read English?

Can

Communication:

Information obtained from: Patient, spouse, parent, child, other relative, friend other: Phone Interview

High Cholesterol

High Blood Pressure

Blood clots to lung/legs Ulcers of Stomach Cancer or Leukemia Stroke(s) Diverticulosis Alzheimer's or Dementia Arthritis

Thyroid

Heart Attack(s) Diabetes Hiatal Hernia Seizures Prostate Problems

Angina Asthma

Liver Disease

Low back pain problems

Ovary/Uterus Prob.

Irregular Heart Beat

Emphysema/COPD

Hepatitis

Immune deficiency

Dialysis

Heart Murmur Pneumonia Anemia Glaucoma Chronic Pain

Rheumatic Fever

Kidney Stones

Radiation Therapy Infectious Process

Sleep Apnea

Con estive Heart Fail. Kidne Infection Chemothera Renal Failure Diabetic Retina Dis.

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

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | Open Heart | Gall Bladder |  | Hip Repair |  | Cataracts/eyes/laser surgery Pacemaker |
|  | Angioplasty-Balloon | Appendix |  | Ankle or Knee |  | Ears or tonsils Implanted Defibrillator |

Artery Surgery

Ostomy

Type:

## I PSFH: Family History of

Bowel Blockage Stomach

Back or Neck Tubes tied

Mouth Uterus or Ovaries

Kidney Stone Removal

IV Device

VP Shunt

Hypertension Diabetes Cancer

## I Personal History

Alcohol use

## I Social History

Cigarettes Illicit drugs

Married Widowed Occu ation Livin Situation

## ROS: Recent Symptoms

General 29. Dizziness

How long:

1. Weight change: amt.

Time Frame \_

1. Fever/Chills or Sweats
2. Tired all the time
3. Loss of appetite

Time Frame \_

1. Poor Appetite

Time Frame Head & Neck

Headaches-

What pain medication is used? How often?

How long has med been taken?

I Eyes

1. Worsening vision
2. Eye discharge

8. Tern ora loss of vision Ears, Nose Mouth and Throat

1. Ringing in the ears
2. Nosebleeds
3. Runny or stuffy nose
4. Sore throat
5. Difficulty swallowing

14. Hoarse voice

Respiratory

1. Short of breath at rest
2. Short of breath on exertion
3. Cough
4. Wheezing
5. Phlegm

10. Major Pulmonary infection Pneumonia

Bronchitis

Chest (Breasts)

30. Breast lump

30. Discharge

Gastrointestinal

1. Heart Burn
2. Stomach pains
3. Nausea
4. Vomiting
5. Vomiting blood
6. Difficulty swallowing

*Change in Bowel Movement*

1. Black color
2. Bloody
3. Diarrhea
4. Constipation

Genitourinary

1. Painful urination
2. Frequent urination
3. # or times you urinate at night
4. Hard to urinate
5. Blood in urine

Hematologic/Lymphatic

1. Bleed easily
2. Bruise easily

59. Swollen lands Blood/Transfusion Information

1. Previous blood transfusion
2. Designated donor

What pain medication is used? How often?

How long has med been taken?

Skin

1. Rash
2. Sores or wounds
3. Itchy

Skin Cancer Neurologic

1. Convulsions/seizures
2. Passing out
3. Headaches
4. Loss of memory

76. Numbness/tingling Psychiatric

1. Depressed feelings
2. Anxious or panic feelings

79. Can't sleep due to worries Endocrine

1. Hair or skin change
2. Thirsty often
3. Weight change
4. Energy change

No thyroid or any other endocrinopathy On Thyroid Medications?

How long?

Medication Allergies?

I Allergy/Immune

1. Hives
2. Sneezing
3. Sweats and chills
4. Recent steroid use

Cardiovascular

1. Other
2. Chest pains or pressure
3. Racing heart
4. Irregular heart beats
5. Wake up short of breath
6. Need 2+ pillows at night
7. Leg cramps from walking

Musculoskeletal

1. Joint/Muscle swelling or pain
2. Back or neck pain
3. Leg swelling
4. Unable to walk on own
5. Type of device needed
6. Swelling of extremities
7. Fatigue 68. Bed ridden