Modern Kidney & Transplant Care
25329 Interstate 45, Suite 129, The Woodlands, TX 77380

Please Complete the Following Questionnaire

Name: _____ **Date of Birth:** _____ **Email Address:** _____

Street Address: _____ **City:** _____ **State:** ___ **Zip:** _____

Home Phone: _____ **Cell Phone:** _____ **PCP:** _____

Primary Insurance: _____ **Secondary Insurance:** _____

Preferred Pharmacy: _____ **Referring Provider:** _____

Do you have an Advance Directive? (Living will, Power of Attorney, Do Not Resuscitate) ☐ YES ☐ NO

Date of your last blood draw (Month/Year) _____ Where? ☐ Western Nephrology ☐ Other

Date of your last Flu Vaccine (Month/Year) _____

Have you developed any NEW allergies since your last visit? ☐ YES ☐ NO

If yes, please explain: _____

_____

Have you had any surgery since your last visit? ☐ YES ☐ NO

If yes, please explain: _____

_____

Have you been hospitalized since your last visit? ☐ YES ☐ NO

If yes, please explain: _____

_____

Do you smoke? ☐ YES ☐ NO

Do you drink alcohol? ☐ YES ☐ NO

Do you use recreational drugs? ☐ YES ☐ NO

Any changes in your history since your last visit (e.g. social, medical, or family changes)**?** ☐ YES ☐ NO

Have you experienced any of the following symptoms ***since your hospital visit?***

*****Do Not Include Chronic Symptoms*****

	Y	N		Y	N		Y	N
Change in appetite			Painful joints			Difficulty urinating		
Shortness of breath at rest			Unexplained Weight Gain			Unexplained Weight Loss		
Heart trouble			Shortness of breath with exertion			Chest Pain		
Abdominal Pain			Swelling of ankles			Nausea/Vomiting		
Blood in urine			Diarrhea			Painful urination		