CENTRAL FLORIDA KIDNEY SPECIALISTS

Name/Nombre_____DOB/Fecha de Nacimiento_____
Civil Status / Estado Civil (circle one / circule uno): *Single / Soltero(a)* *Partnered / Convivo* *Married / Casado(a)* *Divorced / Divorciado(a)* *Widowed / Viudo(a)*
Are you retired? /Está usted retirado? Yes/Sí___ No___ Do You work?/Usted Trabaja?_____
Primary Care Physician/Doctor de Cabezera: _____
List all the doctors who treat you/Escriba el nombre de todos los doctors que lo atienden:
_____

PERSONAL HEALTH HISTORY

Past Surgical History/Historial De Cirugias

Year/Año	Surgery Name/Nombre de la cirugía
	Heart Catheterization/Cateterización Del Corazón
	Open Heart/Cirugía De Corazon Abierto
	Appendix Surgery/Cirugía del Apendice
	Gallbladder/Vesícula
	Hysterectomy/Histerectomía
	Carotid Surgery/Cirugía De La Carotida
	Knee Replacement/Reemplazo De Rodillas
	Hip Replacement/Reemplazo De Caderas
	Eye Laser Surgery/Cirugía De Laser
	Kidney Stones Removal/ Remoción De Piedras En El Riñon
	Other_____ _____ _____

Past Medical History/Historial Medico

___High Blood Pressure/Presión Alta
___Strokes/Derrame Cerebral
___ Heart Attack/Ataque al Corazón
___Diabetes/Diabetes
___Insulin/Insulina___Pills/Pastillas
___High Cholesterol/Colesterol Elevado
___Angina/Dolor de Pecho
___Congestive Heart Failure/Insuficiencia Cardiaca
___Lung Disease/Enfermedades del Pulmon
___Prostate Problems/Problemas de la Prostata
___Thyroid Problems/Problemas de la Tiroide
___Seizures/Ataques Epilepticos
___Cancer of_____/Cancer de_____
___Depression/Depresión
___Kidney Stones/Piedras en el Riñon
___Arthritis/Artritis
___Asthma/Asma
___Gastrointestinal Problems/Problemas Gastrointestinal
___Other_____

Allergies to Medication/ Alergias a Medicamentos

Medication Name/Nombre del Medicamento	Reaction/Reacción
1	
2	
3	
4	
5	
6	

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Social History/Historial Social

1. Where were you born? /Donde nació usted? _____
2. Have you ever smoked? Usted Fuma? ___YES/SI___NO
- **If yes**, check one of the following: Everyday____Socially___Past Use___ When did you quit?_____
- **Si usted fuma**, marque uno de los siguientes: A diario?____Socialmente_____¿Cuándo dejó de fumar?
3. Do you consume alcoholic drinks? Usted consume bebidas alcoholicas? YES/SI__NO____
   If yes,how much? Cuánto? _____Type/Tipo_____Frequency/Frecuencia_____
4. Do you drink coffee? /Usted toma café? How many cups?/Cuántas tazas? _____
5. Have you had a blood transfusion? Ha tenido usted una transfusion de sangre? YES/SI__ No_
6. Do you use any illicit drugs? Utiliza drogas ilegales? YES/SI__NO_
   If yes, check one of the following: Present use? __Past use_____What type?____
   Si utiliza, marque una de las siguientes: Utiliza actualmente?__En el pasado?__ Qué tipo?_____

Family History/Historial Familiar

use an X to mark if applicable/marque con una X si aplica

Condition Condición	Father/ Padre	Paternal Grandfather/ Abuelo Paterno	Paternal Grandmother/ Abuela Paterna	Mother/ Madre	Maternal Grandfather/ Abuelo Materno	Maternal Grandmother/ Abuela Materna	Siblings/ Hermanos	Child/ Hijos
High Blood Pressure/ Presión Alta								
Diabetes								
Cardiac Problems Problemas Cardiacos								
Renal Dialysis Diálisis Renal								
Kidney Stones/ Piedras en el riñón								
Alzheimer's Disease								
Pulmonary Disease/ Problemas Pulmonares								
Cancer Type_____								
Other								

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Medication List/Lista de Medicamentos

Patient Name/Nombre de Paciente_____

Pharmacy/Farmacia_____Address/Dirección_____

Pharmacy Phone Number/Teléfono de la Farmacia_____

LIST YOUR MEDICATIONS INCLUDING PRESCRIBED DRUGS, OVER THE COUNTER MEDICATIONS, VITAMINS, AND INHALERS. ENUMERE SUS MEDICAMENTOS, INCLUYENDOS LOS MEDICAMENTOS RECETADOS, VITAMINAS E INHALADORES.		
Name of medications/Nombre del Medicamento	Strength/Dosis	Frequency/Frecuencia
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		
16.		
17.		
18.		

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CONSENT TO USE OR DISCLOSE INFORMATION FOR TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS

The patient hereby consents to the use or disclosure or his/her individually identifiable health information (protected health information) and patient medical record information by **CENTRAL FLORIDA KIDNEY SPECIALISTS, Inc.** (the practice) in order to carry out treatment, payment or health care operations. The patient should review the Practice's Notice of Privacy Practices for more complete description of the potential uses and disclosures of such information and the patient has the right to review such Notice priority signing this Consent Form.

The practice reserves for itself the right to change the terms of its Notice of Privacy Practices at any time. If the practice does change the terms of its Notice of Privacy Practices, patient may obtain copy of revised Notice.

Patient retains the right to request that the practice further restrict how his/her protected health information is used or disclosed to carry out treatment, payment or health care operations. The practice is not required to agree to such requested restrictions; however, if the practice does agree to patients requested restriction(s), such restrictions are then binding on the practice.

Patient acknowledges and agrees that the practice may disclose patients protected health information and patient medical record information to the following individuals who are either the patients family members, legal representatives, guardian, health care surrogates or have power of attorney on behalf of the patient: **(patient must fill out) NAME / RELATIONSHIP:** _____

_____

The patient agrees that the Practice may disclose the following types of information contained in the patients' medical records (please initial, do not check, the appropriate categories listed below):

Restrictions

____ HIV/AIDS Information_____

____Substance Abuse Information_____

____Sexually Transmitted Disease Information_____

____Mental Health Information _____

_____If patient is under the age of eighteen (18), Pregnancy Information_____

Patient agrees and consents to the practice releasing information to patient in the following alternative manners (please initial, do not check the appropriate spaces below):

____ Via e-mail to the Patients designated e-mail address which is: _____

____ Via Regular Mail with any envelopes being marked personal and confidential and addressed to patient.

____ Via Telephone, if patient contacts the practice and provides the appropriate information (including the patients name, social security number and date of birth).

At all times, patient retains the right to revoke this consent. Such revocation must be submitted to the practice in writing. The revocation shall be affective except to the extent that the practice has already taken action in reliance on the consent. If you revoke this consent, Central Florida Kidney Specialists, Inc. will only continue to treat you on an emergency basis and in the case for 30 days.

The practice may refuse to treat patient if he/she (or an authorized representative) does not sign this consent form. If patient (or authorized representative) sign this consent and then revokes it, the practice has the right to refuse to provide further treatment to patient as the time of revocation (except to the extent that the practice is required by law to treat individuals).

I HAVE READ AND UNDERSTAND THE INFORMATION IN THIS CONSENT. I MAY RECEIVE A COPY OF THIS CONSENT AND I AM THE PATIENT OR AM AUTHORIZED TO ACT ON BEHALF OF THE PATIENT TO SIGN THIS SEALED DOCUMENT VERIFYNG CONSENT TO THE ABOVE STATED TERMS.

Date: _____ Time: _____AM/PM

_____ _____

Signature of patient / Authorized Representative* Print Name

*Please explain representatives relationship to patient and include a description of representatives authority to act on behalf of the patient. Please attach proof of guardianship with a court document.