## Southeastern Clinical Research Institute, LLC

## **Renal and General Research**

Date:		Social Security Number:					
Name:							
First			Middle		Last		
Address:							
Street				City	State	Zip Code	
Phone:				Phone:			
Home					Mob	ile	
Physician:			Hospital:				
Are you allergic to any medica	ations?	Yes	No If yes,	please list:			
In the past have you ever had	?						
Surgery on your arteries?	Yes	No	Date:		_		
Heart Attack?	Yes	No	Date:		_		
Coronary Bypass Surgery?	Yes	No	Date:		_		
Stroke?	Yes	No	Date:		_		
Kidney Problems?	Yes	No	Date:		_		
Thyroid Problems?	Yes	No	Date:		_		
Liver Problems?	Yes	No	Date:		_		
Cancer?	Yes	No	Date:		_		

ease List any surgeries:						
ave you ever had any of the following	<b>J</b> ?					
Angina		Migraines				
Periphrial Vascular Disease		High Blood Pressure				
Dialysis/Kidney Machine		Diabetes				
Asthma		Diabetic Nephropathy				
Bronchitis		Heart Failure				
Emphysema		Anemia				
Cataracts		Gout				
Glaucoma		Heartburn				
Headaches		Esophageal Reflux Disease (GERD)				
Depression		Environmental Allergies				
Fatigue		Anemia				
nen was your last X-Ray?						
you use the following?						
Cigarettes	1	Nicotine				
Alcohol		Caffeine				
Recreational Drugs						
hat medications are you currently ta	How Often?	Date Started?				
	How Often?					
	How Often?	Date Started?				
	How Often?					