MEDICAL QUESTIONNAIRE

Please fill in English

Patient Information			
Name			
Date of birth			(MM/DD/YYYY)
Age			
Sex			
Blood type			
Country			
Address			
Phone number			
Emergency contact person	Name		
	Phone number		

◎Medical history

Drug allergies	☐ No		
	☐ Yes		
History of clinical hepatitis	Hep. B:	No	
		Yes	
	Hep. C:	No	
		Yes	
Etiology of chronic renal failure			

◎Schedule			
Visiting date	From		(MM/DD/YYYY)
	To		(MM/DD/YYYY)
Dialysis requested date	1		(MM/DD/YYYY)
	2		(MM/DD/YYYY)
	3		(MM/DD/YYYY)
Hotel name			
Hotel phone number			

Dialysis Treatment

☐ HD (hemodialysis) ☐ HDF (hemodiafiltration) ☐ other	
Type of replacement fluid (in case of HDF)	
Type of dialyser	
Surface area	
Type of vascular access	
Vascular acess site	
Type of needle	
Note	

Date of dialysis treatment for the first time		(YYYY/MM/DD)
Dialysis hour per one time		Hours
Number of sessions per week		/week
Date of last scheduled dialysis before the requested date		(YYYY/MM/DD)
Usual water removal rate		ml/min
Blood flow		ml/min
Dialysate flow		ml/min

Erythropoiesis stimulating agent	☐ required ☐ not required
type op ESA	
Dose / Cycle	/
Administration	☐ Subcutaneous ☐ Intravenous

Anticoagulant	☐ Heparin sodium ☐ Dalteparin sodium ☐ Nafamostat mesilate ☐ not required		
Applied dose	initial dose		/hour
	Hourly dose		
	time off		

Blood pressure	Pre-dialysis		mmHg
	Post-dialysis		mmHg

Weight	Dry weight		kg
	Average weight gain		kg

LABORATORY DATA

Lab Test	Date	Result	
Hemoglobin			g/dl
Hematocrit			%
BUN (Blood urea nitrogen)			mg/dl
Creatinine			mg/dl
Potassium			mEq/L
Calcium			mg/dl
Phosphate			mg/dl
AST			IU/L
ALT			IU/L

Please enclose laboratory copy

(Within 3 months valid date)

HBs Ag / Ab (/) HCV ( ) HIV ( ) VDRL ( )

ECG(Electrocardiogram)		
Date of examination		(YYYY/MM/DD)
Chest X-ray		
Date of examination		(YYYY/MM/DD)
CTR(Cardio thoracic ratio)		%

Medications list

Active ingredient	Brand name	Quantity

Note: Please bring your own supply of oral medication(s)

Special Instructions	
Possible problems during session	
Medications during or at the end of session	

REFERRING DIALYSIS UNIT INFORMATION

Referring M.D.	
Referring hospital	
Hopital Phone number	
Address	
Date	
Agreement	I certify that the information given regarding _____ (patient's name) is correct and permission is granted by _____ (physician's name)
Physician's Signature	