

(Complete all questions. Please contact your physician for assistance if necessary.)

Name of primary applicant: \_\_\_\_\_ ID/SSN: \_\_\_\_\_

Form No. \_\_\_\_\_

Name of person treated: \_\_\_\_\_ Relationship to applicant: \_\_\_\_\_

1. What type of kidney or urinary disorder did you have? Please check all that apply.

**Bladder infection.** Date symptoms first occurred: \_\_\_\_\_ What date did you last have symptoms? \_\_\_\_\_  
How many occurrences have you had? \_\_\_\_\_ List any medications prescribed for this condition, include amount taken  
per day and how often per day: \_\_\_\_\_

**Involuntary urine loss.** Date symptoms first occurred: \_\_\_\_\_ What date did you last have symptoms? \_\_\_\_\_  
How many occurrences have you had? \_\_\_\_\_ List any medications prescribed for this condition, include amount taken  
per day and how often per day: \_\_\_\_\_

**Kidney stones.** Date symptoms first occurred: \_\_\_\_\_ What date did you last have symptoms? \_\_\_\_\_  
How many occurrences have you had? \_\_\_\_\_ List any medications prescribed for this condition, include amount taken per  
day and how often per day: \_\_\_\_\_

**Nephritis.** Date symptoms first occurred: \_\_\_\_\_ What date did you last have symptoms? \_\_\_\_\_ How many  
occurrences have you had? \_\_\_\_\_ List any medications prescribed for this condition, include amount taken per day and  
how often per day: \_\_\_\_\_

**Prostate.** Date symptoms first occurred: \_\_\_\_\_ What date did you last have symptoms? \_\_\_\_\_ How many  
occurrences have you had? \_\_\_\_\_ List any medications prescribed for this condition, include amount taken per day and  
how often per day: \_\_\_\_\_

**Cystitis.** Date symptoms first occurred: \_\_\_\_\_ What date did you last have symptoms? \_\_\_\_\_ How many  
occurrences have you had? \_\_\_\_\_ List any medications prescribed for this condition, include amount taken per day and  
how often per day: \_\_\_\_\_

**Reflux.** Date symptoms first occurred: \_\_\_\_\_ What date did you last have symptoms? \_\_\_\_\_ How many  
occurrences have you had? \_\_\_\_\_ List any medications prescribed for this condition, include amount taken per day and  
how often per day: \_\_\_\_\_

**Renal failure.** Date symptoms first occurred: \_\_\_\_\_ What date did you last have symptoms? \_\_\_\_\_  
How many occurrences have you had? \_\_\_\_\_ List any medications prescribed for this condition, include amount taken per  
day and how often per day: \_\_\_\_\_

**Other:** \_\_\_\_\_

2. Other than medications, have you received any other treatment for this condition (such as special therapy, dialysis, bladder  
training treatments, etc)? \_\_\_\_\_

3. Have you had any of the following testing done? Check all that apply.

- Blood test       Renal biopsy       Urine test       Renal scan       Ultrasound  
 Renal angiography  Cystoscope       24 hour urine       Cystogram

If yes, give dates of testing and results: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4. Have you ever been hospitalized for this condition?  Yes  No If yes, please give details such as name and address of hospital, date of admission and discharge, surgery or testing that was done and results: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

5. Have you ever had any heart trouble or high blood pressure?  Yes  No If yes, please explain (ie, date condition started, surgery, medications) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

6. Name and address of treating physician: \_\_\_\_\_

\_\_\_\_\_

7. Please list your exact current height: \_\_\_\_\_ weight: \_\_\_\_\_

All of the above statements are true, complete and correctly recorded to the best of my knowledge. I understand American Community will rely on these statements when determining eligibility.

\_\_\_\_\_  
Signature of person treated (or parent/guardian if under 18)

\_\_\_\_\_  
Date