Western Nephrology

Caring for People with Kidney Disorders

Name:
DOB:
Date of Appointment:

Please list all doctors you currently see (Primary Care Physician and Specialists i.e. Cardiologist):

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Please list any medications you currently taking along with **dosage and directions** (including birth control, vitamins and OTC medications):

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____

____

Please list **any allergies** you have:

____

____

Medical History – Health Conditions

	Yes	No		Yes	No		Yes	No
Kidney Disease: (if yes, please specify)			Kidney Stones			Diabetes/High Blood Sugar		
Irregular Heart Beat			Tuberculosis			Stroke		
High Blood Pressure			Gallstones			Epilepsy/Seizures		
Heart Attack			Liver Disease: *(if yes, please specify)*			Thyroid Problems		
Heart Murmur						Anemia		
Rheumatic Fever			Ulcers in Stomach/Bowel			Asthma		
High Cholesterol			Bleeding from Bowels			Cancer: *(if yes, please specify)*		
Congestive Heart Failure			Arthritis			Blood Transfusion		
Emphysema/ Chronic Bronchitis			Prostate Problems			Depression		
Blood Clot in Lung			Gout			Anxiety		
Blood Clot in Leg			Skin Disease: *(if yes, please specify)*			Other: *(if yes, please specify)*		
Bleeding Problems: *(if yes, please specify)*								

Surgeries

	Yes	**Date**	No		Yes	**Date**	No
Nephrectomy				Bladder surgeries			
Cataract Surgery *(if yes, please specify)*				Joint Scope Surgery			
Tonsils Removed				Knee/Hip Joint Replacement			
Neck Artery Surgery				Back Disk Surgery			
Open Heart Surgery/Catheterization				Prostate Surgery			
Appendectomy				Hernia Surgery			
Gallbladder Removal				Vasectomy			
Abdominal Surgery				Hysterectomy			
Broken Bone Repair *(if yes, please specify)*				Other/Additional surgeries *(if yes, please specify)*			

Family Medical History

(Please specify relation to you i.e. mother, father, sister, brother, child, etc.)

	Relation		Relation		Relation
Heart Attack		Kidney Disease		Diabetes/High Blood Sugar	
High Blood Pressure		Gout/Arthritis		Liver Disease	
High Cholesterol		Osteoporosis		Alcohol Abuse	
Asthma		Stroke		Anxiety or Depression	
Tuberculosis		Epilepsy/Seizures		Glaucoma	
Cancer: *(if yes, please specify)*		Bleeding Problems		Other: *(if yes, please specify)*	

How many siblings do you have? ____________________ How many brothers? ____________________ How many sisters? ____________________
How many children do you have? ____________________ How many boys? ____________________ How many girls? ____________________

Other History

Exercise *(please check frequency)*: ☐ Often ☐ Rarely ☐ Never
Have you ever smoked? *(please check)*: ☐ Yes ☐ No

If Yes:

- For how many years? ____________________
- If you have stopped smoking, when did you quit? ____________________
- If you currently smoke, how many packs per day? ____________________
- Do you use smokeless tobacco? (i.e. chewing tobacco) ________________

Alcohol/Drugs

- Do you drink alcohol? ____________________
  - If yes, how often did you have a drink containing alcohol in the past year? (Never, monthly or less, 2-4 times a month, 2-3 times a week, 4 or more times a week)
  - If yes, how many drinks did you have on a typical day when you were drinking in the past year? (1 or 2, 3 or 4, 5 or 6, 7-9, 10 or more)
  - If yes, how often did you have 6 or more drinks on one occasion in the past year? (never, less than monthly, monthly, weekly, daily, almost daily)
- Do you currently use recreational drugs? ____________________
  - If yes, how often and which drugs? ____________________
  - If no, have you used recreational drugs in the past? ____

Marital Status: ☐ Single/Never married ☐ Married ☐ Divorced ☐ Widow/Widower
Living with: ____________________
Your Occupation: ____________________

Female Patients Only

Pregnancy		
	How many pregnancies have you had? If yes, have you had preeclampsia or proteinuria?	
	How many deliveries?	
	How many elective abortions?	
	How many miscarriages?	
Reproductive Health		
	What was the date of your last menstruation?	
	If applicable, what age did you go through Menopause?	
	When was your last Pap Smear?	
	Have you ever had an abnormal Pap Smear? • If yes, when? • What was the abnormality? • What treatment did you have?	
	When was your last Mammogram?	
	Have you ever had an abnormal Mammogram? • If yes, when? • What was the abnormality? • What treatment did you have?	

Current Physical Condition (check yes or no)

		Yes	No
General/Constitutional	Chills		
	Fatigue		
	Fever		
	Night sweats		
	Unexplained weight gain		
	Unexplained weight loss		
Head/Eyes/Nose/Throat	Frequent headaches		
	Severe headaches		
	Wear glasses/contacts		
	Chronic nasal discharge		
	Impaired hearing		
	Diabetic eye disease		
Endocrine	Thyroid problems		
	Excessive hunger		
	Cold intolerance		
	Excessive thirst		
	Heat intolerance		
Respiratory	Asthma		
	Cough		
	Shortness of breath with exertion		
	Wheezing		
Cardiovascular	Heart trouble		
	Swelling of ankles		
	Rheumatic Fever		
	Chest pain		
	Irregular heartbeat		
	Palpitations		
Gastrointestinal	Hemorrhoids		
	Rectal disease		
	Abdominal pain		
	Blood in stool		
	Change of bowel habits		
	Constipation		
	Decreased appetite		
	Diarrhea		
Hematology	Anemia		
	Excessive bleeding		
	Abdominal bleeding		
	Swollen glands/lymphnodes		

Current Physical Condition Continued (check yes or no)

		Yes	No
Women Only	Birth control use (if yes please specify)		
	Problems with sexual function		
Men Only	Lump in groin		
	Scrotal pain		
	Problems with sexual function		
Genitourinary	Blood in urine		
	Difficulty urinating		
	Frequent urination		
	Painful urination		
	Urinary Tract Infections		
Musculoskeletal	Chronic back pain		
	Medication for pain		
	Painful joints		
Skin	Oral ulcers		
	Itching		
	Rash		
	Skin cancer		
Neurological	Trouble sleeping		
	Frequent depression		
	Anxiety		
	Nervousness		
	Convulsions		
	History of a stroke		
	Numbness in fingers/toes		
	Dizziness		
	Fainting		
	Memory loss		
	Seizures		