

LIST ANY MEDICAL PROBLEMS AND DURATION:

LIST MEDICATIONS WITH DOSES THAT CURRENTLY ON:

SURGICAL PROCEDURES WITH DATES:

ARE YOU EXPERIENCING? YES NO HOW LONG?

ANY FAMILY HISTORY OF: YES NO RELATIONSHIP?

High Blood Pressure			
Diabetes			
Anemia			
Cancer			
High Cholesterol			
Kidney Stones			
Cysts in Kidney			
Anyone on Dialysis			
Lupus-Autoimmune Disorders			
AIDS or AIDS Related			
Asthma			
Hereditary Kidney Condition			
Heart Disease			
Liver Disease			
Vein or Artery Disease			
Lung Disease			
Gastrointestinal Disease			
Protein or Blood in Urine			
Potassium Wasting			
Problems with Pregnancy			

Metallic Taste in morning?			
Lower Extremity Swelling?			
Rashes? Bruising?			
Shortness of Breath?			
Anemia? Loosing Blood?			
Uncontrolled Blood Pressure?			
Lead Exposure?			
Bleeding Disorders			
Stroke Vascular Disease			
Excessive Urination at Night			
Poor Urinary Stream			
Frequent Urination Burning			
Foam in Urine			
Heat or Cold Intolerance			
Confusion			
Hearing Loss			
Abdominal or Flank Pain			
Appetite Poor			
Joint Pains Arthritis Where			
Weight Gain or Weight Loss			
Swelling in Legs or Ankles			
Changes in Urination			
Blood in Urine			
Visual Problems			
Dizziness or Light-Headaches			
Nausea or Vomiting			
Difficulty with Breathing			
Pain in Legs after walking			
Sleep Disturbances			
Skin Rash Itching			
Fatigue or Weakness			
Kidney Stones			
Problems with Pregnancy			
Psych Problems (Lithium use)			

ANY COMPLICATIONS OR PROBLEMS NOT LISTED ANYWHERE ELSE?

Kidney Transplant?			
Kidney Removal?			

Are your Parents Alive? ___ Cause of Death _____

Who do you live with? _____

How many siblings or kids do you have? _____

What type of work do you do? _____

Any Ultrasound or Imaging of your Kidney? Yes No

Taking NSAID s (Aleve, Tylenol, or Ibuprofen)? Yes No

Any recent CAT scan or MRI with contrast? Yes No

Drink Alcohol? Yes No

Using Street Drugs? Yes No

Tobacco Use? Yes No

Taking Herbal Supplements? Yes No

Any Recent Antibiotics Yes No

Allergies? Food, Drugs or Environment? Yes No

Do you have a "Do not Resuscitate Order" in place Yes No

Race: White/Caucasian Hispanic Asian African American Native Hawaiian or Other

Signed Name _____ Printed Name _____

Who referred you to our office? _____ Who is your primary care physician? _____

If yes for how long: _____

If yes name them: _____

If yes for how long _____

If yes name them: _____