COMPREHENSIVE KIDNEY CARE

LIST ANY MEDICAL PROBLEMS AND DURATION:	LIST MEDICATIONS WITH DOSES THAT CURRENTLY ON:

SURGICAL PROCEDURES WITH DATES:

____

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			

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? _________________________

ARE YOU EXPERIENCING?	YES	NO	HOW LONG?
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 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 If yes for how long:_______________________________

Taking Herbal Supplements? ☐ Yes ☐ No If yes name them:_______________________________

Any Recent Antibiotics ☐ Yes ☐ No If yes for how long _______________________________

Allergies? Food, Drugs or Environment? ☐ Yes ☐ No If yes name them:_______________________________

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?** ____________________ _