History and Review of Systems

Please complete to the best of your ability prior to your new patient appointment. 08/2006

Reason for Referral:			
Renal History:	**Yes**	**No**	**Comments:**
1) Any kidney x-rays such as ultrasound, IVP or Cat Scan? • When? • Where?			
2) Prior 24-hour urine?			
3) History of blood in urine?			
4) History of protein in urine?			
5) Use any pain pills? • List type and amount.			
6) Do you check your blood pressure at home? • Type of cuff? • Results? • Last time the cuff was checked for accuracy?			
7) History of urinary tract infection, bladder infection or kidney infection?			
8) History of kidney stones?			
9) Do you get up at night to urinate? How many times?			
10) Do you lose your urine (incontinence)?			
11) Any burning, pain or discomfort urinating?			
12) Any flank pain?			
13) Trouble with leg swelling?			
14)Any kidney or bladder surgery?			
Relevant Current History:	**Yes**	**No**	**Comments**
1) High blood pressure? • How many years? • Last change in medications? • What are your blood pressure readings?			
2) Diabetes? • Eye damage? (laser treatment) • Nerve damage (numbness, decreased feeling in feet)? • Kidney damage? • Impotence?			

Review of Symptoms:	**Yes**	**No**	**Comments**
Constitutional			
• Weight change?			
• Fevers?			
• Chills?			
• Sweats?			
Eyes			
• Last eye exam?			
• Any damage from diabetes?			
• Any damage from high blood pressure?			
Ears, Nose and Throat			
• Dentures?			
• Hearing difficulty?			
Pulmonary			
• Cough?			
• Smoking			
• History of asthma or COPD?			
• Shortness of breath with exertion?			
Cardiovascular			
• Chest pain with exertion?			
• Any prior heart surgery?			
• Any prior cardiac catheterization?			
• Any prior stress test?			
• Prior echocardiogram?			
• Cardiologist's Name?			
Gastrointestinal			
• History of gastrointestinal bleeding?			
• History of recurrent nausea and vomiting?			
• Prior endoscopy (stomach evaluation)?			
• Prior colonoscopy (bowel evaluation)?			
• Heart burn or indigestion?			
• Ulcer disease?			

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	Yes	No	Comments
Musculoskeletal			
• Gout?			
• Muscle aches?			
• Joint aches?			
• Pain pills (include over the counter)?			
Vascular			
• Prior arteriogram of dye x-ray of abdomen, legs, neck or brain)			
• Angioplasty (Balloon opening of blood vessels)?			
• Stent?			
• Surgical bypass?			
• Aneurysm of aorta?			
• Cramping in legs with walking?			
Skin			
• Rash?			
• Skin cancer?			
Neurologic			
• TIA or mini-stroke?			
• Stroke; location weakness? Date?			
• History of seizures?			
• History of nerve damage?			
• Carotid ultrasound?			
• CT scan or MRI of the brain?			
Endocrine			
• History of high or low blood sugar?			
• Thyroid problems?			
• Cholesterol problems?			
• Pre/post menopausal?			
• Osteoporosis?			
• Vertebral fractures or other fractures?			
• Bone density study?			

Blood or Cancer Problems			
• History of anemia or low blood counts?			
• History of easy bruising or bleeding?			
• Do you take a blood thinner?			
• Do you have a history of cancer?			
	Yes	**No**	**Comments:**
Psych			
• Depression?			
• Anxiety?			

Allergies? (Please list below)

Medications? (Please list below and bring in to your appointment. Be sure to include over the counter medications, mineral and herbal supplements)

Past Medical History (Please list problems and any recent hospitalizations)

Past Surgical History (Please list any surgeries and dates)

Family Medical History	**Yes**	**No**	**Comments:**
• Anyone with kidney stones?			
• Anyone with kidney disease, such as protein or blood in urine or kidney failure?			
• Anyone with high blood pressure?			
• Anyone with heart or blood vessel disease?			
• Other (Please specify):			

Social History	**Yes**	**No**	**Comments:**
• Do you work?			
• Do you use tobacco?			
• Do you use alcohol?			
• Do you use drugs?			
• What is/was the health status of your siblings?			
• What is/was the health status of your parents?			
• What is/was the health status of your children?			