	Status	Anemia	Auto Immune Disease	Cancer	Diabetes	Hyper-tension	Kidney Stone Disease	Stroke	Heart Disease	Dementia	Kidney Disease	Kidney Transplant
Mother	Alive well / Deceased											
Father	Alive well / Deceased											
Brother	Alive well / Deceased											
Sister	Alive well / Deceased											
Sibling 1	Alive well / Deceased											
Sibling 2	Alive well / Deceased											
Sibling 3	Alive well / Deceased											
Other-	Alive well / Deceased											
Other-	Alive well / Deceased											

Tobacco Use	Never Former Current	Start Date: _____	Quit Date: _____	Type:	Cigar Pipe Cigarettes	Packs per Day	_____	Years used: _____
Smokless Tobacco	Never Former Current	Start Date: _____	Quit Date: _____	Type:	Snuff Chew	Amount per Day	_____	Years used: _____

Alcohol	Yes Not Currently Never	Glasses of wine _____	Cans of Beer _____	Shots of Liquor _____	Alcholic drinks per Day _____	Comment _____	

Substance Abuse	Yes Never Not Currently	Type:	Amphetaine	Amyl Nitrate	Barbituate	Benzodiazepine	Crack Cocaine	Cocaine	Codeine	Fentanyl	Flunitrazepam	GHB
			Hashish	Heroin	Hydrocodone	Hydromorphone	Ketamine	LSD	Marijuana	MDMA Ecstacy	Mescaline	Metham- phetamins
			Metha - Qualone	Methyl-phenidate	Morphine	Nitrous Oxide	Opium	PCP	Steriod	Psilocybin	Solvent inhalants	Other

Living Arrangement	☐	Lives alone	☐	Spouse/ Significant Other	☐	Family Member	☐	In Home Care Giver	☐	Assisted Living Facility	☐	Nursing Home

Cognitive	☐	Impairment	☐	Memory Deficient	☐	Hearing Loss	☐	Poor Vision or Blindness	☐	Limited Mobility	☐	Transportation Challenges

Medical History

Acute Kidney Inj.	Yes	No	GERD	Yes	No	Lupus	Yes	No
Anemia	Yes	No	Gout	Yes	No	Myocardial Infarction	Yes	No
Atrial Fib	Yes	No	Hepatitis B	Yes	No	Neprotic Syndrome	Yes	No
Cancer	Yes	No	Hepatitis C	Yes	No	Osteoarthritis	Yes	No
CHF	Yes	No	HIV/AIDS	Yes	No	Osteoporosis	Yes	No
Chronic Kidney Disease	Yes	No	Hyperkalemia	Yes	No	Polycystic Kidney	Yes	No
Clotting Disorder	Yes	No	hyperlipidemia	Yes	No	Pyelonephritis	Yes	No
COPD	Yes	No	hyperparathyroidism	Yes	No	Renal Cyst	Yes	No
Coronary Artery Disease	Yes	No	hypertension	Yes	No	Sleep apnea	Yes	No
Diabetes Mellitus	Yes	No	hyponatremia	Yes	No	Stroke	Yes	No
Diabetic Neuropathy	Yes	No	hypothyroidism	Yes	No	TIA	Yes	No
End Stage Renal Disesae	Yes	No	Kidney Stones	Yes	No	UTI	Yes	No

Surgical History

Abdomen Surgery	Yes	No	Hysterectomy	Yes	No	Kidney Transplant recipient Living related Donor	Yes	No
Bladder Surgery	Yes	No	Kidney Biopsy	Yes	No	Kidney Transplant recipient Living unrelated Donor	Yes	No
CABG	Yes	No	Kidney Removal	Yes	No	Lithotripsy	Yes	No
Cardiac Stent	Yes	No	Kidney Stone Surgery	Yes	No	Parathyroid Surgery	Yes	No
Dialysis Access Surgery	Yes	No	Kidney Transplant	Yes	No	Thyroid Surgery	Yes	No
Gallbladder Surgery	Yes	No	Kidney Transplant Recipient deceased donor	Yes	No		Yes	No

Symptoms

Fever	Blurred Vision	Heartburn	Easily Bruise
Chills	Eye Discharge	Nausea	Excessive Thirst
Rash	Chest pain	Vomiting	Dizziness
Nosebleeds	Palpitations	Abdominal Pain	Weaknss
Sore Throat	Leg Swelling	Painful Urination	Seizure
Nosebleeds	Cough	Urinary Urgency	Depression
	Shortness of Breath	Urinary Frequency	Nervous/Anxious
		Blood in Urine	Insomnia
		Joint Pain	