NEPHROLOGY AND HYPERTENSION SPECIALISTS, P.C.

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PATIENT NAME:_____DATE COMPLETED:_____

PLEASE LEAVE THIS SPACE BLANK FOR DOCTOR'S NOTES:

PLEASE ANSWER ALL THE QUESTIONS:

Do you understand why you were referred to a kidney specialist? Yes No

Have you ever been told that you have kidney failure? Yes No

Have you ever been told that you have hypertension? Yes No

If yes, how long you had high blood pressure? _____ years

Do you have a family history of high blood pressure? Yes No

If yes, who in your family has or had hypertension? _____

Have you gained or lost any weight in the past year? Yes No

Do you have a tremor of your hands? Yes No

Do you have flushing spells or episodes of a rapid heartbeat? Yes No

Do you use over-the-counter nasal decongestants, nasal sprays, or appetite suppressants regularly? Yes No

Do you snore? Yes No

Are you tired and sleepy throughout the day? Yes No

Have you ever been diagnosed with sleep apnea? Yes No

Do you have diabetes? Yes No

Please answer the following questions if you have diabetes:

How long have you had diabetes? _____ years

Have you ever had a problem with diabetes affecting your eyes? Yes No

Have you ever had laser therapy for your eyes? Yes No

If yes, when was it done?_____

Have you been told you have a stomach problem related to your diabetes?	Yes No
Do you have numbness in your hands or feet?	Yes No
Have you ever had kidney stones?	Yes No
Have you ever had recurrent urinary tract infections?	Yes No
Did you have urinary tract infections as a child?	Yes No
Are you taking any type of prescription or over-the-counter pain pill?	Yes No
Have you ever taken a great deal of pain medicines such as Motrin, Advil, or Naprosyn?	Yes No
Have you ever had blood in your urine?	Yes No
Have you ever been a moonshine drinker?	Yes No
Do you have a family history of kidney disease or any family members on dialysis?	Yes No
Is there a family history of blood in your urine?	Yes No
Do you have any swelling in your legs?	Yes No
Do you have any trouble starting your urine?	Yes No
Do you ever wet yourself?	Yes No
Has your urine stream slowed with age?	Yes No
Have you ever had prostate gland trouble? (Men only)	Yes No
Have you ever taken Lithium?	Yes No
Have you started any new medications lately?	Yes No
Have you ever had radiation to the area of the kidneys?	Yes No
Do you use any folk or herbal medicines?	Yes No
Have you ever worked around cadmium, mercury, or uranium?	Yes No
Have you ever had any form of hepatitis or other liver disease?	Yes No
Do you have any form of arthritis such as lupus, osteoarthritis, or rheumatoid arthritis?	Yes No

REVIEW OF SYSTEMS:

Constitutional:

Have you had any chills or fever lately?	Yes No
Do you have night sweats?	Yes No
Do you have any swollen glands?	Yes No
Do you have a problem with fatigue?	Yes No

Skin:

Do you have any rashes now or when you go out in the sun?	Yes No
Do you have any skin lesions that are changing color or growing?	Yes No
Have you had any tightening of the skin around your mouth or fingers?	Yes No
Have you had any recent skin infections?	Yes No

Eyes:

Is your vision failing?	Yes No
Do you have any irritation of your eyes?	Yes No

ENT:

Are you having any facial swelling?	Yes No
Has your tongue changed size recently?	Yes No
Have you had chronic sinus problems?	Yes No
Do you have difficulty hearing?	Yes No
Have you been to the dentist in the last six months?	Yes No
Do you have any infected teeth?	Yes No
Do you have trouble swallowing?	Yes No
Do you have frequent sores in the mouth?	Yes No
Has your hat size changed?	Yes No

Cardiovascular:

Do you have any chest pain?	Yes No
Do you have any shortness of breath when you lay down at night?	Yes No
Are you short of breath on exertion?	Yes No
Have you ever had a heart attack?	Yes No
Have you ever had a stroke?	Yes No

Gastrointestinal:

Have you had any blood in your stools?	Yes No
Have your bowel habits changed recently?	Yes No
Have you ever vomited blood?	Yes No

Genitourinary:

Have you ever had surgery on your prostate gland? (Men) Yes No

Have you had any surgery on your kidneys and bladder? Yes No

Endocrine:

Do you have any disorder of your thyroid gland? Yes No

Has your hat size changed? Yes No

Pulmonary:

Do you have asthma or wheezes? Yes No

Do you have lung disease from smoking? Yes No

Have you coughed up any blood? Yes No

Musculoskeletal

Do you have gout? Yes No

Neurologic

Do you have a history of seizures? Yes No

Do you have a problem with anxiety or depression? Yes No

GYN

Do you have any lumps in your breasts? Yes No

Have you undergone menopause? Yes No

If not, have you missed any periods? Yes No

Hematology

Do you or anyone in your family have sickle cell disease or sickle cell trait? Yes No

Is there a family history of any type of cancer? Yes No

Have you ever been told that you are anemic? Yes No

Do you have any swollen glands? Yes No

Past Medical History and Health Maintenance:

When was your last flu shot? Month_____ Year_____

Have you had the pneumococcal vaccine?

If so, when? Month_____ Year_____

When was your last colonoscopy? Month_____ Year _____

Women Only

When was your last pap smear? _____

When was your last mammogram? _____

Social History:

Are you married? Yes No

If so, for how long? _____

Is this your only marriage? Yes No

What was your last grade of school completed? _____

What is your occupation? (If retired, what was your occupation?) _____

Please list your hobbies or interests _____

Habits:

Do you smoke?

If yes, how much and for how long? _____

Were you a previous smoker? _____

If yes, when did you stop and how much did you smoke before stopping? _____

Do you drink two or more alcoholic beverages a day? Yes No

Have you ever had any problem with any type of alcohol or drug addiction? Yes No

Do you drink more than 6 cups of coffee a day? Yes No

Are you currently using any illegal drugs or do you have a past history of using any illegal drugs? Yes No

Past Medical History:

Please list below all surgeries, hospitalizations, or other significant illnesses you have had and the date:

_____ _____

_____ _____

_____ _____

_____ _____

Family History:

Does diabetes run in your family? Yes No

Is there a history of heart attack under age 50 in your family? Yes No

Is there a history of cancer in your family? Yes No

Is there a history of kidney stones in your family? Yes No

Is there any history of stroke in your family? Yes No

How many siblings do you have? _____

How many children do you have? _____

Please list any health issues, or if appropriate, cause of death:

Mother: _____

Father: _____

Siblings: _____

_____

_____

Children: _____

_____

_____

PLEASE BRING ALL MEDICATION BOTTLES TO YOUR OFFICE VISIT

Medication Allergies:

Please list drug and type of reaction:

_____ _____

_____ _____

_____ _____

Thank you for your time in completing this form. We look forward to meeting you.

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