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**PLEASE PRINT ON FORM** Account #:_____ **PLEASE USE BLACK INK**

# Nephrology New Patient Questionnaire

**Patient Name: _____ Date of Birth: _____/_____/_____**

**Long Term/Mail Order Pharmacy:_____**

**Short Term/Local Pharmacy:_____Pharmacy Phone: ____-____-_____**

**Pharmacy Address:_____ State: _____ Zip: _____**

## Medical History

**Please Check Any of the Following Conditions that you are currently being treated for or have had within the past 10 years and the year you were first diagnosed/treated.**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| ❑ High Blood Pressure | Year: _____ | ❑ Congestive Heart Failure | Year: _____ | ❑ Bleeding from Digestive Tract | Year: _____ | ❑ Thyroid Disease | Year: _____ |
| ❑ Diabetes | Year: _____ | ❑ High Cholesterol | Year: _____ | ❑ Liver Disease | Year: _____ | ❑ Gout | Year: _____ |
| ❑ Eye Problems from Diabetes | Year: _____ | ❑ Heartburn (Acid Reflux) | Year: _____ | ❑ Hepatitis B or C | Year: _____ | ❑ Migraine Headaches | Year: _____ |
| ❑ Heart Attack | Year: _____ | ❑ Emphysema | Year: _____ | ❑ Enlarged Prostate | Year: _____ | ❑ Seizures | Year: _____ |
| ❑ Stents in Heart | Year: _____ | ❑ Chronic Bronchitis | Year: _____ | ❑ Blood Clots | Year: _____ | ❑ Cancer* | Year: _____ |
| ❑ Pacemaker | Year: _____ | ❑ Stroke | Year: _____ | ❑ Arthritis | Year: _____ | *List Types Below | |

**List Cancer Types and any other Medical Conditions you may have had in the past:_____**

_____

_____

**List Any Surgeries you have had and the year it was performed:_____**

_____

_____

## Family History

***Check All That Apply***

| Medical Condition | Father | Mother | Brother | Sister | None |
|---|---|---|---|---|---|
| Kidney Disease | ❑ | ❑ | ❑ | ❑ | ❑ |
| Diabetes | ❑ | ❑ | ❑ | ❑ | ❑ |
| High Blood Pressure | ❑ | ❑ | ❑ | ❑ | ❑ |
| Heart Disease | ❑ | ❑ | ❑ | ❑ | ❑ |
| Cancer | ❑ | ❑ | ❑ | ❑ | ❑ |
| Stroke | ❑ | ❑ | ❑ | ❑ | ❑ |
| Gout | ❑ | ❑ | ❑ | ❑ | ❑ |
| ADPKD-Polycystic Kidney Disease | ❑ | ❑ | ❑ | ❑ | ❑ |
| Dementia | ❑ | ❑ | ❑ | ❑ | ❑ |

## Immunization History

**Have you had these Vaccinations?**

❑ **Flu Vaccine *Within the Past Year***

❑ **Pneumonia Vaccine *Within the Past 5 Years***

**Are you currently or have you ever taken any of the following Medications on a Daily/Weekly Basis?**

**Please Check All that Apply:**

❑ **Advil / Ibuprofen**
❑ **Aleve**
❑ **BC Tablets/Powder**
❑ **Bextra**
❑ **Celebrex**
❑ **Diclofenac**
❑ **Goody's Powders**
❑ **Mobic**
❑ **Motrin**
❑ **Naproxen / Naprosyn**
❑ **Vioxx**
❑ **Voltaren**

## Review of Symptoms Related to your Kidneys

**Check any of these Kidney Related Symptoms that you are Currently experiencing:**

- ❑ **Swelling in Hands / Legs / Feet**
- ❑ **Frequent Urination**
- ❑ **Painful Urination**
- ❑ **Difficulty Starting Urine Stream**
- ❑ **Incomplete Bladder Emptying**
- ❑ **Nose Bleeds**
- ❑ **Shortness Of Breath**
- ❑ **Cough / Wheezing**
- ❑ **Headache / Dizziness**

## Personal History

**Check all that Apply to You:**

| **Tobacco Use** | ❑ **Former** | ❑ **Current** | ❑ **Never** |
|---|---|---|---|
| **Please Circle all that apply** Cigarettes/Pipes/Cigars/Vape Snuff/Chew | When did you Quit? _____ How many years? _____ Packs per day? _____ | How often?_____ Packs per day? _____ | |
| **Alcohol Use** | ❑ **Former** | ❑ **Currently** | ❑ **Never** |
| | When did you Quit?_____ | Rarely / 1-2 Drinks per Day / 3 or more Drinks per Day | |
| **Recreational Drug Use** | ❑ **Former** | ❑ **Current** | ❑ **Never** |

## Allergies

**Please List any Allergies to Medications that you have and what Symptoms you had.**

| Medication | Symptoms |
|---|---|
| | |
| | |
| | |
| | |
| | |

**List any Additional Medications and reactions below if needed:** _____

_____

_____

# Medications

**Please List the Medications you are Currently Taking Below:**

| **Medication** (Example: *Hydralazine*) | **Dosage** (Example: *25mg*) | **Frequency** (Example: *Take 1 Tablet 3 Times a Day*) |
|---|---|---|
| **1** | | |
| **2** | | |
| **3** | | |
| **4** | | |
| **5** | | |
| **6** | | |
| **7** | | |
| **8** | | |
| **9** | | |
| **10** | | |
| **11** | | |
| **12** | | |
| **13** | | |
| **14** | | |
| **15** | | |
| **16** | | |
| **17** | | |
| **18** | | |
| **19** | | |
| **20** | | |

***If your medications exceed this page please bring medications to your apt or bring a typed listed to your appointment.**