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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.**