Cleveland Kidney Disease Associates

Date _____________

Name ____ DOB ________ Age _____

Referring Physician ________________________ Primary Care Physician ____________

Reason for Referral ____

Occupation ___________________ Marital Status ________ Phone Number __________

Medical History

List any past illnesses ____

____

____

List any past surgical procedures (include date/yr if known)

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Check any of the following you have experienced

_____ Heart problems (including heart failure, attack, murmurs)

_____ Cancer

_____ Lung problems (including emphysema, asthma)

_____ Liver problems (including hepatitis, jaundice, gall bladder disease)

_____ Thyroid problems

_____ Kidney problems (blood or protein in your urine, stones, frequent infections)

_____ High blood pressure

_____ Arthritis

_____ Stroke, mini-stroke

____ Diabetes (sugar)

Do you smoke?_____ (now or in the past) How much per day? _____ How many years? _____ When did you quit? _____

Do you use drugs? (now or in the past) _____Marijuana _____ Cocaine _____ Heroin _____Other _____

Do you drink alcohol?_____ How much per week? ___________________________________

Do you follow any specific diet? _____ If yes, explain ____

____

Allergies to medications ____

(including reactions, if known)____

Current medications ____

____

____

Family Medical History (include high blood pressure, cancer, heart, kidney or lung disease, stroke, diabetes and inherited diseases)

Relationship	Age	Health problems	Cause of death
Father			
Mother			
Brothers			
Sisters			
Children			

General Health Review

Please check any of the following you are experiencing

General

___Decreased appetite
___Food tastes strange/different
___Weight loss in past 6 months
___Weight gain in past 6 months
___More easily fatigued
___Fevers
___Sweating at night
___Hair loss
___Change in your skin
___New/changing/bleeding moles
___Rash
___Depression

Head

___Headaches
___Blurred vision
___Double vision
___Decreased hearing
___Ringing in your ears
___Frequent nosebleeds
___Trouble swallowing foods
___Mouth sores

Heart and Lungs

___Chest pain or heaviness
___Racing heart/skipped beats/palpitations
___Short of breath at rest
___Short of breath lying flat
___Wake up and have to sit up to breathe
___Have to sleep propped up
___Loud snoring
___Cough with mucous and/or blood
___Swelling or edema
___Pain in legs when walking

Gastrointestinal

___Nausea
___Vomiting
___Pain in abdomen
___Frequent constipation
___Frequent diarrhea
___Blood in your stool
___Black stools

Urinary System and Genital Tract

___Frequent urination
___Bladder doesn't empty completely
___Burning or pain with urination
___Blood in urine
___Foamy urine
___Need to wake up to urinate
___Change in force of urine stream
___Trouble starting or stopping urinating
___Dribbling after urination
___Losing urine spontaneously
___Losing urine after coughing/sneezing
___Impotence
___Change in your periods
___Bleeding after menopause
___Bleeding between periods

Muscles, Joints, Nervous System

___Muscle aching or cramps
___Joint pains
___Joint swelling
___Arthritis
___Fainting
___Seizures
___Numbness or tingling anywhere
___Weakness anywhere
___Paralysis anywhere
___Trouble speaking/making words
___Discoloration of hands and/or feet

Physician/Provider to Complete Reviewed with patient on: ____________________/____________________
DD/MM/YY Provider initials