Renal Physicians Questionnaire

Date: _____

Patient Name: _____ **DOB:** _____

PLEASE BRING ALL OF YOUR MEDICATIONS OR A DETAILED LIST TO EVERY VISIT

NAME OF MEDICATION	STRENGTH OF MEDICATION	HOW OFTEN DO YOU TAKE

Please list any food or drug allergies: _____

Past Medical History: Please list medical problems that you are currently receiving treatment for.

Problems	Doctor Treating this problem

Hospitalizations: Please list any hospital stays.

Month/Year	Hospital	Reason in the Hospital

Please continue on the other side….

Surgical History: Please list all prior surgeries.

Month/Year	Hospital	Surgery performed

Family History:

Is your father living? ☐ Yes ☐ No Year of birth or age of death: _____

Father's known health problems: _____

Is your mother living? ☐ Yes ☐ No Year of birth or age of death: _____

Mother's known health problems _____

How many siblings, living or deceased? _____

Sibling's known health problems? _____

Do you have children? Boys? _____ Girls? _____

Child/Children's known health problems? _____

Do you:	Yes	No	How long and how much
Use tobacco?	☐	☐	
Use alcohol?	☐	☐	
Use street drugs/needles?	☐	☐	

Relevant history:

Use of Advil, Ibuprofen or Aleve	☐	Yes	☐	No
Use of Herbal or Chinese supplements	☐	Yes	☐	No
Difficulty in urinating/poor stream	☐	Yes	☐	No
Urinary urgency, frequency, incontinence	☐	Yes	☐	No
Get up often at night for urination	☐	Yes	☐	No
Flank pain	☐	Yes	☐	No
Blood in urine or changes in color	☐	Yes	☐	No
Leg swelling	☐	Yes	☐	No
Weight gain	☐	Yes	☐	No
Breathing difficulty	☐	Yes	☐	No
Nose bleeds or sinus problems	☐	Yes	☐	No
Skin rash	☐	Yes	☐	No
Recent IV dye	☐	Yes	☐	No
Pregnancy related kidney disease	☐	Yes	☐	No
Recurrent UTI's	☐	Yes	☐	No

_____ _____

Your Signature Physician Signature

_____

Date