CAROLINA NEPHROLOGY, PA

New Patient History

Name: _____ DOB: _____ Sex: _____ Date: _____

Chief Complaint:

1. Give a brief description of the problem you are seeking treatment for today:

2. Have you been evaluated for this problem or had any tests for this problem? _____ Yes _____ No

   If yes, give the name of the physician who did your evaluation or ordered your tests: _____

   What tests were performed? _____

3. Who referred you for this appointment? _____

4. List any other physicians you see routinely: _____

5. Have you ever seen a nephrologist? _____ Yes _____ No If yes, the physician's name: _____

6. Have you ever: _____ had a kidney biopsy? Dates: _____

   _____ had any recent lab tests for kidney function? Dates: _____

   _____ had any 24 hour urine collections? Dates: _____

   _____ had any prior kidney ultrasounds? Dates: _____

Past Medical History:

Have you had problems with any of the following?

	Yes	No	If yes, please explain:
Cancer	( )	( )	
Diabetes	( )	( )	
High Blood Pressure	( )	( )	
Heart Problems	( )	( )	
High Cholesterol	( )	( )	

Emphysema or Asthma..... ( ) ( )

Ulcers..... ( ) ( )

Liver Disease..... ( ) ( )

Kidney Problems..... ( ) ( )

Protein in Urine..... ( ) ( )

Kidney Stones..... ( ) ( )

Cysts/Masses/Cancer in the Kidneys..... ( ) ( )

Prostate Disease..... ( ) ( )

Thyroid Gland Problems..... ( ) ( )

Hemorrhages or Bleeding..... ( ) ( )

Anemia..... ( ) ( )

Arthritis..... ( ) ( )

Convulsions or Seizures..... ( ) ( )

Laser Eye Surgery for Diabetic Eye Disease..... ( ) ( )

Numbness and Tingling..... ( ) ( )

Foot Ulcers or Circulatory Disorders..... ( ) ( )

Erectile Dysfunction..... ( ) ( )

Psychiatric Treatment..... ( ) ( )

Treatment for Depression or Anxiety..... ( ) ( )

Surgeries:

Month/Year	Procedure

Prior Hospitalizations:

Month/Year	Procedure

Current Medications:

Medication	Strength	How Often Taken	Medication	Strength	How Often Taken

_____ _____ _____ _____ _____
_____ _____ _____ _____ _____
_____ _____ _____ _____ _____
_____ _____ _____ _____ _____
_____ _____ _____ _____ _____
_____ _____ _____ _____ _____
_____ _____ _____ _____ _____
_____ _____ _____ _____ _____
_____ _____ _____ _____ _____

Have you ever taken:

	Yes	No	
Advil / Ibuprofen / Motrin / Aleve?	( )	( )	If yes, please list: _____
Over-the-Counter Decongestants?	( )	( )	If yes, please list: _____

Drug Allergies:

	Yes	No
Are you allergic to any medications:	( )	( )

If yes, please list the medications:
_____
_____
_____

Social History:

Marital Status: ( ) Married ( ) Single ( ) Separated ( ) Divorced ( ) Widowed

Number of Children: _____

Education: Highest Grade Completed: _____ Highest Degree Completed: _____

Occupation: _____ Work Status: ( ) Full Time ( ) Part Time ( ) Unemployed

( ) Retired ( ) Student ( ) Disabled

If you are retired, what was your previous occupation?
_____

Habits:

	Yes	No	How much?	How many years?
Do you smoke?	( )	( )	_____	_____
If no, have you ever smoked?	( )	( )	_____	_____
Do you drink alcohol?	( )	( )	_____	_____
If no, did you previously drink?	( )	( )	_____	_____
IV drug abuse?	( )	( )	_____	_____
Had blood transfusions?	( )	( )	_____	_____
Have any tattoos?	( )	( )	_____	_____

Family History:

Living:	Present Age/ Age at Death	Present Health or Cause of Death

Spouse: ( ) Yes ( ) No _____

Father: ( ) Yes ( ) No _____

Mother: ( ) Yes ( ) No _____

Children: ( ) Yes ( ) No _____

Number of Brothers: _____ Number of Sisters: _____ Have any of your family members had a condition similar to yours?

If yes, please describe:

_____

_____

_____

Please answer the following questions:

Constitutional Symptoms:	Yes	No
Recent Weight Change	( )	( )
Fever	( )	( )
Fatigue	( )	( )
Sleep Difficulty	( )	( )
Loss of Appetite	( )	( )

Gastrointestinal:	Yes	No
Abdominal Pain	( )	
Cramps	( )	
Nausea	( )	
Vomiting	( )	
Diarrhea	( )	
Constipation	( )	
Liver Problems	( )	( )
Jaundice (yellow color in eyes & skin)		( )

Eyes/Ears/Nose/Mouth/Throat:		
Eye Problems	( )	( )
Hearing Loss or Ringing in Ears	( )	( )
Chronic Sinus Problems	( )	( )
Nose Bleeds	( )	( )
Sore Throat or Voice Change	( )	( )
Swollen Glands in Neck	( )	( )
Difficulty Chewing or Swallowing	( )	( )

Musculoskeletal:	Yes	No
Joint Pain	( )	
Joint Stiffness or Swelling	( )	
Weakness of Muscles	( )	
Muscle Pain or Cramps	( )	
Back Pain	( )	

Cardiovascular:		
Chest Pain or Angina	( )	( )
Irregular Heartbeat or Pounding Heart	( )	( )
Swelling of Feet, Ankles or Hands	( )	( )
Calf Pain When Walking	( )	( )
Aneurysm History	( )	( )
Do You Sleep Flat	( )	( )
Do You Use 2 or 3 Pillows	( )	( )

Integumentary (Skin):	Yes	No
Rash or Itching	( )	
Change in Hair or Nails	( )	
Change in Skin Color	( )	
Change in Color or Size of Moles	( )	

Do You Wake Up from Sleep Short of Breath……..…. ( )

( )

( )

Respiratory:

( )

Chronic or Frequent Coughs……..… ( )

( ) ( )

Spitting Up Blood……. ( )

( ) ( )

Shortness of Breath……. ( )

( ) ( )

Asthma or Wheezing……... ( )

( ) ( )

( )

( )

( ) **Neurological:**

Seizures……. ( )

Dizziness or Vertigo……. ( )

Loss of Consciousness…….…… ( )

( ) Numbness or Tingling Sensations…….……

( ) Weakness in Limbs……

( ) Difficulty With Balance……..

( ) Frequent or Recurring Headaches…….…….

Tremors…….. ( )

Memory Loss or Confusion…… ( )

Psychiatric:

	Yes	No
Any Psychiatric Disorders…….……	( )	( )
Nervousness……	( )	( )
Depression……	( )	( )
Hallucinations…….……	( )	( )
Paranoia or Suspiciousness…….……	( )	( )

( )

( )

Endocrine:

( )

Adrenal Glands and Disorders…….	( )	( )
Excessive Thirst or Urination……	( )	( )
Heat or Cold Intolerance…….	( )	( )
Addison ’s Disease or Pituitary Disorders……	( )	( )

Hematologic/Lymphatic:

Bleeding or Bruising Tendency……	( )	( )
Inflammation in Leg Veins (Phlebitis)…….……	( )	( )
Cancer……	( )	( )
Clots in Leg Veins……	( )	( )
Anemia……..	( )	( )
Transfusions……..	( )	( )
Excessive Bleeding……	( )	( )

Genitourinary:

	Yes	No
Frequent Urination……	( )	( )
Burning or Painful Urination……	( )	( )
Blood in Urine……	( )	( )
Loss of Control of Urine……..	( )	( )
Male Erectile Difficulty……..	( )	( )
Kidney Stones……	( )	
Foamy Urine……	( )	
Decreased Caliber of Stream……..	( )	
Getting Up at Night to Urinate……	( )	( )
Hesitance or Difficulty in Starting Urine…..…	( )	( )