SNOWY RANGE
KIDNEY CARE

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

Why are we seeing you?_____

List allergies and state reaction, if known. Circle, 'none', if you have no allergies.

_____
_____
_____
_____

Medications you are taking (include, all prescriptions, OTC meds, vitamins, herbals)
Medication Name Dose (mg, mcg, ml, etc) How Often?(daily, twice daily, etc)

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Family History: Please list family members with following health issues:

- Kidney disease: _____
- High blood pressure:_____
- Diabetes:_____
- Cardiovascular disease:_____
- Stroke:_____
- Cancer(type, if known):_____
- Auto-immune disease (eg lupus, rheumatoid arthritis)_____
- Other:_____

Patient Name:_____

Social History

- **Tobacco smoking status**: Never smoker Former Smoker Current smoker
- **Smokeless Tobacco status**: Never smoker Former Smoker Current smoker
- **If current tobacco use, please estimate how much?**_____packs per day.
- **Alcohol intake: Please estimate number of drinks**: _____ per day/per week.
- **Recreational drug use**: ___None _____
- **Occupation**:_____
- **Exercise**:_____
- **Who do you live with**?_____

Past Surgical History- Please list any surgeries/procedures you have had and estimated date

_____
_____
_____
_____

Past Medical History

Yes	No	Kidney disease	_____
Yes	No	Kidney Transplant	_____
Yes	No	Other Organ Transplant	_____
Yes	No	Kidney stone	_____
Yes	No	Kidney infection	_____
Yes	No	Prostate Enlargement (BPH)	_____
Yes	No	Hypertension	_____
Yes	No	Coronary artery disease	_____
Yes	No	Congestive heart failure	_____
Yes	No	Heart disease	_____
Yes	No	Atrial fibrillation	_____
Yes	No	Abdominal Aortic Aneurysm	_____
Yes	No	Peripheral Vascular Disease	_____
Yes	No	Stroke/Mini Stroke	_____
Yes	No	High cholesterol	_____
Yes	No	Diabetes	_____
Yes	No	Thyroid disease	_____
Yes	No	Electrolyte Imbalance	_____

Patient Name:_____

Past Medical History (continued)

Yes	No	Emphysema/COPD	_____
Yes	No	Asthma	_____
Yes	No	Sleep Apnea	_____
Yes	No	Cancer (specify)	_____
Yes	No	Anemia/Low Blood Count	_____
Yes	No	Blood transfusion	_____
Yes	No	Blood clots legs or lungs	_____
Yes	No	Lupus or Auto-immune	_____
Yes	No	Arthritis	_____
Yes	No	Gout	_____
Yes	No	Acid Reflux (GERD)	_____
Yes	No	Liver disease (hepatitis)	_____
Yes	No	HIV infection	_____
Yes	No	Infectious Disease/COVID	_____
Yes	No	Seizure/Epilepsy	_____
Yes	No	Depression/Anxiety	_____

Other medical history not listed above: -

_____
_____
_____
_____

Please continue to page 4 for the review of systems

Patient Name:_____

Review of Systems: Circle any conditions you have experienced in the past month

Renal/Urinary: Blood in urine/cola colored urine, Protein in urine, Difficulty urinating, Increased urine production, Pain during urination, Incontinence

Constitutional: Fever, Chills, New weight loss (____pounds), Loss of energy, Loss of Appetite, Frequent headaches

Eyes: Blurred vision, Double vision, Eye Pain/irritation, Vision Change, Loss of Vision

Ears/Nose/Mouth: Sinus problems, Nosebleeds, Sore throat, Mouth sores

Heart: Chest pain/discomfort, Ankle or leg swelling, Calf pain with walking

Lungs: Frequent coughing, Trouble breathing/short of breath, Shortness of breath when walking, Shortness of breath when lying down

Stomach: Stomach pain, Frequent nausea, Frequent vomiting, Frequent diarrhea, Frequent heartburn or indigestion

Muscles and Bones: Joint pain, Frequent muscle aches, Swelling in the arms or legs, Swelling in the joints, Recent broken bones or fractures

Skin: Rash, Persistent itching

Neurologic: Recent changes or loss of memory, numbness or tingling in hands/feet, recent pain in hands/feet

Endocrine: Extreme tiredness, Extreme intolerance to cold or hot, excessive thirst/fluid intake

Hematologic/Lymphatic: Swollen glands, blood clotting problems

Mental Wellness: Lack of interest in life activities, Feeling depressed, Extreme anxiety

Describe any other new concern you want your provider to know:_____
_____