KSM

KIDNEY SPECIALISTS
OF MINNESOTA

Today's Date: _____/_____/_____

Patient Name: _____Date of Birth: _____/_____/_____

DO YOU HAVE A PERSONAL HISTORY OF . . .	YES	NO	DETAILS
KIDNEY DISEASE			Kidney Disease: Dialysis: ☐ Hemodialysis ☐ Peritoneal Dialysis Transplant: ☐ Cadaveric ☐ Living-Related ☐ Living-Unrelated ☐ Polycystic Kidney Disease ☐ Acute Kidney Injury ☐ Glomerulonephritis
DIABETES			☐ Type 1 ☐ Type 2 ☐ Type Unknown
HIGH BLOOD PRESSURE			☐ Essential ☐ White Coat Hypertension
HEART DISEASE			☐ Heart Attack ☐ Angina ☐ Angioplasty ☐ CABG ☐ Coronary Stent
CANCER			Type:
STROKE			
GOUT			
CARDIOVASCULAR			☐ Atrial Fibrillation ☐ Valvular Heart Disease ☐ Pacemaker ☐ Congestive Heart Failure ☐ AICD (Cardiac Defibrillation) ☐ Mitral Valve Prolapse
RESPIRATORY			☐ COPD ☐ Chronic Bronchitis ☐ Asthma ☐ Emphysema ☐ Pneumonia ☐ Tuberculosis ☐ Sleep Apnea
GASTROINTESTINAL			☐ GERD (Gastric Reflux) ☐ Inflammatory Bowel Disease ☐ Stomach/ Bowel Ulcers ☐ Irritable Bowel Syndrome ☐ Gall Bladder Disease ☐ Hepatitis ☐ Gluten Intolerance ☐ Lactose Intolerance
GENITOURINARY			☐ Enlarged Prostate ☐ Frequent Urinary Tract Infections ☐ Kidney Stones
OB History			☐ Preeclampsia ☐ Gestational Diabetes ☐ Pregnancy Induced Hypertension ☐ History of Complicated Pregnancy
MUSCULOSKELETAL			☐ Osteoarthritis ☐ Osteoporosis
NEUROLOGICAL			☐ Multiple Sclerosis ☐ Parkinson's ☐ Seizures ☐ Dementia
PSYCHIATRIC			☐ Depression ☐ Anxiety
ENDOCRINE			☐ Hypothyroidism ☐Hyperthyroidism ☐ Adrenal Insufficiency
HEMATOLOGY			☐ Anemia ☐ Sickle Cell Disease ☐ Sickle Cell Trait ☐ Blood Transfusion ☐ Thalassemia
IMMUNO/ALLERGY			☐ HIV ☐ AIDS ☐ Rheumatoid Arthritis ☐ Lupus
OTHER			Other Health Problems Not Listed Above:

Patient Name: _____

SURGERY HISTORY	YES	NO	DETAILS
			☐ Appendectomy ☐ CABG ☐ Carotid Endarterectomy ☐ Cataract Surgery ☐ D&C ☐ Gall Bladder Removal ☐ Gastric Bypass ☐ Hemorrhoidectomy ☐ Hernia Repair ☐ Hip Replacement, ☐ LEFT ☐ RIGHT ☐ BILATERAL ☐ Knee Replacement, ☐ LEFT ☐ RIGHT ☐ BILATERAL ☐ Hysterectomy ☐ Prostatectomy ☐ Nephrectomy ☐ Renal Transplant ☐ Thyroidectomy ☐ Tonsillectomy ☐ Valve Replacement ☐ AV Fistula ☐ AV Graft ☐ PD Catheter ☐ Other: _____

FAMILY HISTORY	YES	NO	DETAILS
KIDNEY DISEASE			☐ Father ☐ Mother ☐ Sibling ☐ Child
DIABETES			☐ Father ☐ Mother ☐ Sibling ☐ Child
HIGH BLOOD PRESSURE			☐ Father ☐ Mother ☐ Sibling ☐ Child
HEART DISEASE			☐ Father ☐ Mother ☐ Sibling ☐ Child
CANCER			☐ Father ☐ Mother ☐ Sibling ☐ Child
STROKE			☐ Father ☐ Mother ☐ Sibling ☐ Child
GOUT			☐ Father ☐ Mother ☐ Sibling ☐ Child
POLYCYSTIC KIDNEY DISEASE			☐ Father ☐ Mother ☐ Sibling ☐ Child
DEMENTIA			☐ Father ☐ Mother ☐ Sibling ☐ Child

FAMILY HISTORY—STATUS	DETAILS
FATHER	☐ Living ☐ Deceased, Age at Death:____ Cause of Death:_____ ☐ Unknown
MOTHER	☐ Living ☐ Deceased, Age at Death:____ Cause of Death:_____ ☐ Unknown

SOCIAL HISTORY—STATUS	DETAILS
CURRENT MARITAL STATUS	☐ Married ☐ Separated ☐ Single ☐ Widowed ☐ Divorced
LIVING ARRANGEMENTS	☐ Alone ☐ Family Member ☐ Spouse ☐ In-Home Caregiver ☐ Significant Other ☐ Assisted Living Facility
OCCUPATION	☐ Retired ☐ Unemployed ☐ Employed, ☐ Full-time OR ☐ Part-time ☐ Student
DEFICITS	☐ Hearing Loss ☐ Poor Vision or Blindness ☐ Limited Mobility ☐ Transportation Challenges
SOCIAL HISTORY—HABITS	**DETAILS**
TOBACCO USER	☐ Unknown ☐ Never Used ☐ Current OR ☐ Former User: Type: ☐ Cigarettes ☐ Chewing Tobacco ☐ Pipes ☐ Snuff ☐ Cigars If a former user, year quit: _____Total Years Using Tobacco: _____ How often do you currently, or did you, smoke? ☐ Every Day ☐ Some Days ☐ Unknown How many packs per day do you currently, or did you, smoke? _____
ALCOHOL USE	☐ Never Used ☐ Current OR ☐ Former User: ☐ Occasional ☐ 1-2 per Day ☐ 3 or More per Day If a former user, year quit: _____
RECREATIONAL DRUG USE	☐ Current or Former User: Type: _____ Year Quit: _____ ☐ Never Used

Patient Name: _____

CURRENT MEDICATIONS
(INCLUDING OVER-THE-COUNTER AND HERBAL MEDICATIONS)

Please **bring all medication bottles to your appointment (preferred**), or list your current medications below, or attach a current list of medications.

NAME	DOSE	NAME	DOSE

Are you allergic or intolerant to any medications? ☐ **NO** ☐ **Yes, please list below:**

MEDICATION	ALLERGY	INTOLERANCE	REACTION