KSM
KIDNEY SPECIALISTS
OF MINNESOTA

Patient Name: _____ Date of Birth: _____/_____/_____

Today's Date: _____/_____/_____ Date of Appointment: __/_____/_____

Please complete below and return to Kidney Specialists of MN in the enclosed stamped envelope at least 7 days prior to your appointment.

	DO YOU HAVE A PERSONAL HISTORY of. . .				
Acute Kidney Injury	Yes/No	GERD	Yes/No	Lupus	Yes/No
Anemia	Yes/No	Gout	Yes/No	Myocardial Infarction	Yes/No
Atrial Fibrillation	Yes/No	Hepatitis B	Yes/No	Nephrotic Syndrome	Yes/No
Cancer	Yes/No	Hepatitis C	Yes/No	Osteoarthritis	Yes/No
CHF	Yes/No	HIV/AIDS	Yes/No	Osteoporosis	Yes/No
Chronic Kidney disease	Yes/No	Hyperkalemia	Yes/No	Polycystic Kidney	Yes/No
Clotting disorder	Yes/No	Hyperlipidemia	Yes/No	Pyelonephritis	Yes/No
COPD	Yes/No	Hyperparathyroidism	Yes/No	Renal Cyst	Yes/No
Coronary Artery Disease	Yes/No	Hypertension	Yes/No	Sleep Apnea	Yes/No
Diabetes Mellitus	Yes/No	Hyponatremia	Yes/No	Stroke	Yes/No
Diabetic Nephropathy	Yes/No	Hypothyroidism	Yes/No	TIA	Yes/No
ESRD	Yes/No	Kidney Stones	Yes/No	UTI (Frequent)	Yes/No

SURGERY HISTORY					
Abdomen Surgery	Yes/No	Hysterectomy	Yes/No	-Living relative Donor	Yes/No
Bladder Surgery	Yes/No	Kidney Biopsy	Yes/No	-Living unrelated donor	Yes/No
CABG	Yes/No	Kidney Removal	Yes/No	Lithotripsy	Yes/No
Cardiac Stent	Yes/No	Kidney Stone	Yes/No	Parathyroid Surgery	Yes/No
Dialysis Access	Yes/No	Kidney Transplant Recipient:	Yes/No	Thyroid Surgery	Yes/No
Gallbladder Surgery	Yes/No	-Deceased Donor	Yes/No	Other-	Yes/No

FAMILY HISTORY	**Please select all that apply:**
Mother: Living/Deceased	☐ Anemia ☐ Autoimmune Disease ☐ Cancer ☐ Diabetes ☐ Hypertension ☐ Kidney Disease ☐ Stroke ☐ Heart Disease ☐ Dementia ☐ Gout ☐ Autosomal Dominance ☐ No Known Problems
Father: Living/Deceased	☐ Anemia ☐ Autoimmune Disease ☐ Cancer ☐ Diabetes ☐ Hypertension ☐ Kidney Disease ☐ Stroke ☐ Heart Disease ☐ Dementia ☐ Gout ☐ Autosomal Dominance ☐ No Known Problems
Sister: Living/Deceased/NA	☐ Anemia ☐ Autoimmune Disease ☐ Cancer ☐ Diabetes ☐ Hypertension ☐ Kidney Disease ☐ Stroke ☐ Heart Disease ☐ Dementia ☐ Gout ☐ Autosomal Dominance ☐ No Known Problems
Brother: Living/Deceased/NA	☐ Anemia ☐ Autoimmune Disease ☐ Cancer ☐ Diabetes ☐ Hypertension ☐ Kidney Disease ☐ Stroke ☐ Heart Disease ☐ Dementia ☐ Gout ☐ Autosomal Dominance ☐ No Known Problems

Maternal Aunt: Living/Deceased/NA	□ Anemia □ Autoimmune Disease □ Cancer □ Diabetes □ Hypertension □ Kidney Disease □ Stroke □ Heart Disease □ Dementia □ Gout □ Autosomal Dominance □ No Known Problems
Maternal Uncle: Living/Deceased/NA	□ Anemia □ Autoimmune Disease □ Cancer □ Diabetes □ Hypertension □ Kidney Disease □ Stroke □ Heart Disease □ Dementia □ Gout □ Autosomal Dominance □ No Known Problems
Paternal Aunt Living/Deceased/NA	□ Anemia □ Autoimmune Disease □ Cancer □ Diabetes □ Hypertension □ Kidney Disease □ Stroke □ Heart Disease □ Dementia □ Gout □ Autosomal Dominance □ No Known Problems
Paternal Uncle: Living/Deceased/NA	□ Anemia □ Autoimmune Disease □ Cancer □ Diabetes □ Hypertension □ Kidney Disease □ Stroke □ Heart Disease □ Dementia □ Gout □ Autosomal Dominance □ No Known Problems
Maternal Grandmother Living/Deceased	□ Anemia □ Autoimmune Disease □ Cancer □ Diabetes □ Hypertension □ Kidney Disease □ Stroke □ Heart Disease □ Dementia □ Gout □ Autosomal Dominance □ No Known Problems
Maternal Grandfather Living/Deceased	□ Anemia □ Autoimmune Disease □ Cancer □ Diabetes □ Hypertension □ Kidney Disease □ Stroke □ Heart Disease □ Dementia □ Gout □ Autosomal Dominance □ No Known Problems
Paternal Grandmother Living/Deceased	□ Anemia □ Autoimmune Disease □ Cancer □ Diabetes □ Hypertension □ Kidney Disease □ Stroke □ Heart Disease □ Dementia □ Gout □ Autosomal Dominance □ No Known Problems
Paternal Grandfather Living/Deceased	□ Anemia □ Autoimmune Disease □ Cancer □ Diabetes □ Hypertension □ Kidney Disease □ Stroke □ Heart Disease □ Dementia □ Gout □ Autosomal Dominance □ No Known Problems

Review of Systems (Areas of Concern)	**Please mark if this is a concern for you (leave blank if not applicable):**
Constitution	□ Fever □ Chills □ Weight loss □ Malaise/Fatigue □ Diaphoresis □ Weakness
Skin	□ Rash □ Itching
HENT (Head/Ear/Nose/Throat)	□ Hearing Loss □ Tinnitus □ Ear Pain □ Ear Discharge □ Nosebleeds □ Congestions □ Stridor□ Sore Throat
Eyes	□ Blurred vision □ Double Vision □ Photophobia □ Eye pain □ Eye discharge□ Eye Redness
Cardiovascular	□ Chest Pain □ Palpitations □ Orthopnea □ Claudication □Leg Swelling
Respiratory	□ Cough □ Hemoptysis □ Sputum Production □ Shortness of Breath □ Wheezing
Gastrointestinal	□ Heartburn □ Nausea/Vomiting □ Abdominal Pain □ Diarrhea □ Blood in stool □ Melena
GU (Genitourinary)	□ Dysuria □ Urgency □ Frequency □ Hematuria □ Flank
Musculoskeletal	□ Myalgias □ Neck Pain □ Back Pain □ Joint Pain □ Falls □ Other
Endo/Heme/Aller	□ Easy Bruise/bleed □ Env Allergies □ Polydipsia
Neurological	□ Dizziness □ Headaches □ Tingling □ Tremor □ Sensory Change □ Speech Change □ Focal weakness □ Seizures □ Other_____
Psychiatric	□ Depression □ Suicidal Ideas □ Substance abuse □ Hallucinations □ Nervous/Anxious □ Insomnia□ Memory Loss □ Other _____

TOBACCO USER	**Tobacco Use** Current/Former/Never	**Smokeless Tobacco** Current/Former/Never	
	Start Date	**Start Date**	
	Quit Date	**Quit Date**	
	Type Cigarettes/Pipe/Cigars	**Type** Chew/Snuff	
	Packs per day		
	Years smoked		

ALCOHOL USE	**Alcohol Use** Yes, Not Currently, Never, Deferred	
	Drinks per Week ____Glasses of Wine ____Cans of Beer ____Shots of Liquor ____Standard Drinks or equivalent	
	Alcohol per Week Total____	
Substance Use	**Drug Use** Yes, Not Currently, Never, Deferred **Types** **Use per Week**	

SOCIAL HISTORY—STATUS	**DETAILS**	
LIVING ARRANGEMENTS	**Lives Alone**	
	Spouse	
	Significant Other	
	Family Memer	
	In Home Caregiver	
	Assisted Living Facility	
Functional/Cognitive	Impairment	Yes/No
	Memory Deficit	Yes/No
	Hearing Loss	Yes/No
	Poor Vision or Blindness	Yes/No
	Limited Mobility	Yes/No
	Transportation Challenges	Yes/No

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	FREQUENCY (HOW OFTEN DO YOU TAKE?)

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

MEDICATION	ALLERGY	INTOLERANCE	REACTION