KSM
KIDNEY SPECIALISTS
OF MINNESOTA

Patient Name _____ Date of Birth _____

Today's Date _____ Date of Appointment _____

PERSONAL HISTORY					
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

SURGICAL HISTORY					
Abdomen Surgery	Yes/No	**Hysterectomy**	Yes/No	**Lithotripsy**	Yes/No
Bladder Surgery	Yes/No	**Kidney Biopsy**	Yes/No	**Parathyroid Surgery**	Yes/No
CABG	Yes/No	**Kidney Removal**	Yes/No	**Thyroid Surgery**	Yes/No
Cardiac Stent	Yes/No	**Kidney Stone**	Yes/No	**Other**:	
Dialysis Access	Yes/No	**Kidney Transplant Recipient:** Living Related/Living Unrelated/Deceased Donor	Yes/No		
Gallbladder Surgery	Yes/No				

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FAMILY HISTORY	
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

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SOCIAL HISTORY		
Tobacco User	**Tobacco Use**	Current/Former/Never
	Smokeless Tobacco	Current/Former/Never
	Start Date	
	Quit Date	
	Type	Cigarettes/Pipe/Cigars/Chew/Snuff
	Packs Per Day	
Alcohol Use	Yes/Not Currently/Never/Deferred	
	Drinks per Week ___ Glasses of Wine ___ Cans of Beer ___ Shots of Liquor ___ Standard Drinks or Equivalent ___ Total per Week	
Substance Use	Yes/Not Currently/Never/Deferred	
	Type	
	Use per Week	
Living Arrangements	Lives Alone/Spouse/Significant Other/Family Member/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

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CURRENT MEDICATIONS
INCLUDING OVER-THE-COUNTER AND HERBAL MEDICATIONS
Please bring all medication bottles to your appointment (preferred), list your current medications below, or attach a current list of medications.

NAME	DOSE	FREQUENCY (HOW OFTEN DO YOU TAKE?)

ALLERGIES

MEDICATION	ALLERGY	INTOLERANCE	REACTION