KSOSN KIDNEY SPECIALISTS OF SOUTHERN NEVADA

Date:	Personal/ Family History

PATIENT INFORMATION

PATIENT NAME (LAST)	(FIRST)	(M.I)	DOB:

PAST MEDICAL HISTORY (Please mark all conditions that you have ever had)

- ☐ Dialysis
- ☐ Prostrate Trouble
- ☐ Vasculitis
- ☐ Kidney Transplant
- ☐ Blood clots
- ☐ Other Organ Transplant
- ☐ Gout
- ☐ Kidney Disease or Nephritis
- ☐ Asthma
- ☐ Liver Trouble or Hepatitis
- ☐ Blood in Urine
- ☐ Kidney Stones
- ☐ Urinary Obstruction
- ☐ Protein in Urine
- ☐ Emphysema
- ☐ Bronchitis
- ☐ Heart Disease
- ☐ Anemia
- ☐ Kidney Cysts
- ☐ Heart Failure
- ☐ Kidney Cancer
- ☐ Stroke
- ☐ Other Cancer
- ☐ High Blood Pressure
- ☐ Diabetes
- ☐ Thyroid Disease
- ☐ Arthritis
- ☐ Lupus
- ☐ Osteoporosis
- ☐ Other Autoimmune Disease
- ☐ Deafness
- ☐ High Cholesterol

SOCIAL HISTORY (Please mark all that apply to you)

Tobacco Use (Any form) ☐ Current- every day ☐ Current- some days ☐ Previous ☐ Never

Alcohol Use ☐ Yes ☐ No

If yes, Number of times per day: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7+

Number of times per week: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7+

Do you use recreational drugs? ☐ Yes ☐ No

When was your last flu vaccine? _____

Who do you live with? ☐ Spouse ☐ Spouse and/ or children ☐ Alone ☐ Other: _____

Highest level of education: ☐ High School ☐ Technical School ☐ College ☐ Post Graduate

PROCEDURES (Please mark all that apply to you)

Have you ever had an ultrasound of the Kidney? ☐ Yes ☐ No

If yes, when and where? _____

Have you ever had a Kidney Biopsy? ☐ Yes ☐ No

If yes, when and where? _____

Have you ever had a Kidney Transplant? ☐ Yes ☐ No

If yes, when and where? _____

Have you ever had a Chest X-Ray? ☐ Yes ☐ No

If yes, when and where? _____

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SURGICAL HISTORY (Please mark all that apply to you)

General Surgery
- ☐ Appendectomy
- ☐ Cholecystectomy
- ☐ Colectomy
- ☐ Gastric Bypass
- ☐ Hernia Surgery
- ☐ Mastectomy
- ☐ Thyroidectomy

Gynecology
- ☐ C-Section
- ☐ Hysterectomy
  - If yes, was it due to cancer?
  - ☐ Yes ☐ No

Urology
- ☐ Kidney Stone Removal

Heart Procedure
- ☐ Pacemaker
- ☐ Heart Valve replacement
- ☐ Coronary Stents
- ☐ Cardiac Catheterization
- ☐ Heart Bypass Surgery
  - If yes, was it single, double, triple, quadruple?
  - ☐ Single ☐ Double
  - ☐ Triple ☐ Quadruple

Nephrology
- ☐ Dialysis Fistula
- ☐ Dialysis Graft
- ☐ Nephrectomy
- ☐ Kidney Transplant

Vascular Surgery
- ☐ Leg artery bypass
- ☐ Carotid endarterectomy
- ☐ Amputation
- ☐ Amputation 2nd
- ☐ Vein Mapping
- ☐ Fistulogram

Nephrology
- ☐ Joint Replacement
- ☐ Prostatectomy
- ☐ Spinal fusion

FAMILY HISTORY (Does anyone in your family currently have or have a history of?)

- ☐ Abnormal bleeding or clotting
- ☐ Alcoholism
- ☐ Allergies
- ☐ Blood Disease
- ☐ Deafness
- ☐ Diabetes
- ☐ Dialysis
- ☐ Heart Attack
- ☐ High blood pressure
- ☐ Kidney Disease
- ☐ Lupus
- ☐ Migraine
- ☐ Polycystic Kidney Disease
- ☐ Psychiatric disease or suicide
- ☐ Seizures or epilepsy
- ☐ Transplant
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ Kidney Cancer
- ☐ Liver Cancer
- ☐ Lung Cancer
- ☐ Prostate Cancer
- ☐ Skin Cancer
- ☐ Thyroid Cancer
- ☐ Other Cancer

REVIEW OF SYMPTOMS (Please mark all that apply)

Constitutional
- ☐ Fatigue
- ☐ Weight Loss
- ☐ Weight Gain
- ☐ Poor Sleep
- ☐ Loss of Appetite
- ☐ Fever

Eyes
- ☐ Problems
- ☐ Pain/ Discharge

ENT
- ☐ Hearing Loss

Cardiovascular
- ☐ Chest Pain
- ☐ Palpitations
- ☐ Ankle Swelling

Musculoskeletal
- ☐ Foot or Joint Pain
- ☐ Backache

Respiratory
- ☐ Shortness of Breath
- ☐ Cough
- ☐ Wheezing

Gastrointestinal
- ☐ Abdominal Pain
- ☐ Nausea & Vomiting
- ☐ Constipation
- ☐ Diarrhea

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REVIEW OF SYMPTOMS CONT. (Please mark all that apply)

Genitourinary

- ☐ Difficulty in Urinating
- ☐ Painful Urination
- ☐ Blood in Urine
- ☐ Blood in Stool

Skin

- ☐ Rash
- ☐ Ulcers

Nervous

- ☐ Headaches
- ☐ Dizziness
- ☐ Fainting

Psychiatric

- ☐ Anxiety
- ☐ Depression

Additional Comments: