Northern Nephrology
Patient Information Form **Date:_____**

Name: First_____ MI _____ Last _____
Address: Street _____ Apt _____
City _____ State _____ Zip Code _____
Date of Birth: _____ **Social Security Number:** _____-____-_____
Home Phone: _____ **Work Phone:** _____
Cell Phone: _____ **Email:** _____
Primary Language: _____ **(Fill in the blank)**
Race (please circle): Native American or Alaska, Asian, Black or African American, Native Hawaiian, Pacific Islander, Caucasian, Chinese, Filipino, Japanese, Other, Decline
Ethnicity (Please circle): Hispanic or Latino, Non Hispanic or Latino, Other, Decline
Primary Care Physician: _____
Referring Physician: _____
Pharmacy:_____

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Emergency Contact: _____
Relationship to Patient: _____
Home Phone: _____ **Work Phone:** _____
Cell Phone: _____ **Email:** _____
Address: Street _____ Apt _____
City _____ State _____ Zip Code _____

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Primary Insurance: _____
ID#: _____ **Group #:** _____
Subscriber:_____ **Subscriber Date of Birth**:_____
Relationship to patient: _____ **Copay:** _____
Insurance Referral (Please circle): Yes or No

Secondary Insurance: _____
ID#: _____ **Group #:** _____
Subscriber:_____ **Subscriber Date of Birth**:_____
Relationship to patient: _____ **Copay:** _____
Insurance Referral (Please circle): Yes or No

1) Why were you referred to our office: _____

_____

2) Please list all of your medications here:

Drug Name	Dose	How taken
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies:

Drug Name	Dose	How taken
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

3) Family History (especially diabetes, heart disease, or heart attack, strokes, kidney disease/dialysis and cancer):

	Alive / Deceased	(If deceased, Age?)	Diseases
- Father	_____	Age _____	_____
- Mother	_____	Age _____	_____
- Siblings:			
Brother/Sister	_____	Age _____	_____
Brother/Sister	_____	Age _____	_____
Brother/Sister	_____	Age _____	_____
- Children			
Son/Daughter	_____	Age _____	_____
Son/Daughter	_____	Age _____	_____
Son/Daughter	_____	Age _____	_____

4) Social History:

Do you smoke? Yes/No How Much? _____ How long? _____Quit _____
Alcohol? Yes/No How Much each week? _____Quit _____
Coffee? Yes/No How Much each week? _____Quit _____
Are you employed? _____ For how long? _____
Please Circle: Married / Single / Divorced / Widowed How many children? _____
With whom do you live? _____
Describe living situation (house/apt/other) _____
Diet: Do you restrict salt? _____ Watch Cholesterol? _____ Dairy? _____
Exercise: Do you exercise? _____ What do you do? _____
How often? _____ How long each time? _____

History Form - Page 2

5) Cardiac Risk Profile:

- Men: Are you over 45 years old? Yes / No
- Women: Are you over 55 years old? Yes / No
- Women: Premature menopause without estrogen therapy? Yes / No
- **Family History** of Heart Disease:
  - Male relative with heart attack before age 55? Yes / No
  - Female relative with heart attack before age 65? Yes / No
- Do you have **high blood pressure** (HBP) or on HBP meds? Yes / No
- Are you a **current smoker**? Yes / No
- Do you have **High Cholesterol** or need meds for this? Yes / No

6) Medical Issues:

- Do you have **High Blood Pressure?** Yes / No
  - How long since you were first told you had hypertension?_____
  - How long since you started medications for this? _____
  - Circle one below regarding how well it is controlled (most of the time)
    1) lower than 135/85
    2) between 135 to 155/85 to 100
    3) higher than 155/100
    4) other (describe): _____

  - Do you check your blood pressure at home? Yes / No
  - How frequently? _____(i.e. once a day/week/month)
- Do you have **Diabetes?** Yes / No
  - How long since you were told you had diabetes? _____
  - How old were you when you were diagnosed? _____
  - Do you require insulin? Yes / No For how long? _____
  - Were you initially diet controlled? Yes / No For how long? _____
  - Are you on oral medications for this? Yes / No For how long? _____
  - What is your average home finger stick reading?
    - Morning _____
    - Afternoon _____
    - Night _____
  - Diabetic eye disease? Yes / No
    - Year started? _____
    - Have you had laser surgery to your eyes? Yes / No
    - When? _____
    - Which eye? _____
  - Do you have "nerve pain" or numbness in your feet/hands? Yes / No
    - Year started? _____
    - Describe? _____
  - Do you have diabetic stomach disease (gastroparesis)? Yes / No
    - Year started? _____
    - Describe? _____
  - Have you had **Kidney Stones in the past?** Yes / No
    - When was your first stone?
    - Which Kidney is involved? (Right/Left/Both) _____
    - How many episodes in the last 5 years? _____
    - How much fluid do you drink daily? _____

Northern Nephrology
History Form - Page 3

- Do you know what type of kidney stone? _____
- Have you ever seen a urologist?_____ When? _____

- Have you had **Urinary Tract Infections?** Yes / No
  - How many in the last year? _____
  - Have you ever had an infection in the kidney? Yes / No
  - When was your last urinary tract infection? _____
- Do you have other known **Atherosclerotic Vascular Disease?** Yes / No
  - Have you ever had a heart attack? Yes / No
  - Have you had a cardiac catheterization? Yes / No When?_____
  - Have you had heart bypass surgery? Yes / No When?_____
  - Have you had leg bypass surgery? Yes / No When?_____
  - Ever had a stroke or TIA? Yes / No When?_____
  - Have you ever had your neck artery "cleaned?" Yes/No When___

7) Other Medical conditions (Please describe and write year started):

- Prostate Disease _____ Thyroid Disease_____
- Emphysema _____ Eye Problems _____
- Asthma _____ Hearing trouble _____
- Seizures _____ Heart murmur _____
- Liver Disease _____ Heart Valve disease _____
- Stomach Ulcers _____ Cancer _____
- Arthritis _____ Last Colonoscopy _____

8) Female Patients:

- Are you still menstruating? Yes / No
- Are your periods regular? Yes / No
- Age of menopause? _____
- Are you on estrogen? _____
- Date of last pap smear? _____
- Date of last mammogram? _____

9) Answer the following about kidney toxins?

- Do you take any form of Ibuprofen (prescription or over the counter?) Yes / No
- Which one (i.e. Advil, Motrin, Naproxen, Celebrex, Vioxx) _____
- What dose? _____
- How often? (i.e. every night, once a week) _____
- For how many weeks/months/years? _____
- For what reason? _____

- Have you been on any of the following medications recently (circle)?
  - Penicillin
  - Rifampin
  - Sulfa
  - Vancomycin
  - Ciprofloxacin
  - Levaquin
  - Cephalosporins
  - Erythromycin
  - Minocycline
  - Trimethoprim/sulfamethoxole (Bactrim)
  - Acyclovir
  - Ethambutol

- Thiazides (HCTZ or Zaroxolyn)
- Furosemide (Lasix)
- Triamterene
- Captopril
- Cimetidine
- Ranitidine
- Phenobarbital
- Nitrofurantoin
- Phenindione
- Phenytoin
- Allopurinol

- Have you had any recent radiology test with "**Dye**"?: Yes / No
  - Which one? Head CT / Chest CT / Abdomen CT / Pelvic CT / Other
  - Why was the CT done? _____
- Have you had any recent **Heart Catheterization Tests?** Yes / No
  - When? _____ Where? _____ Cardiologist?_____
- Have you had any other **Vascular Catheterization Tests?** Yes / No
  - (This would be an "angiogram" of possibly the leg, arm, kidney artery, other)
  - When? _____ Where? _____ Vascular Dr.?_____
  - Why was it done? _____

10) Review of other associated symptoms:

- How do you feel overall? Excellent / Good / Fair / Poor / Terrible
- Weight loss / gain (how much over how long)? _____
- Headaches? _____
- Fever / Chills? _____
- Visual trouble? _____
- Hearing trouble? _____
- Nausea? _____
- Vomiting? _____
- Abdomen Pain? _____
- Diarrhea? _____
- Constipation? _____
- Blood in stool? _____
- Black or tarry stool? _____
- Flank pain? _____
- Bladder discomfort? _____
- Trouble passing urine? _____
- Blood in your urine? _____
- Bubbly or frothy urine?_____
- Pain with urination? _____
- how many times do you wake up to urinate at night? _____
- Breathing trouble? _____
- Wake up at night shor of breath? _____
- Can you sleep "flat" or do you need pillows? _____

Northern Nephrology
History Form - Page 5

- Cough or recent illness? _____
- Chest Pain or pressure? _____
- Palpitations? _____
- Leg swelling? _____
- Pain in your legs when you walk? _____
  - How far can you walk before this starts? _____
  - Does it go away with rest? _____
  - How long before it goes away? _____
- Skin rash? _____
- Skin lumps or bumps? _____
- Are you itchy?_____Where?_____
- Do you have join aches? _____
  - Which ones? _____
  - How long? _____
- Are you joints swollen? _____
  - Which ones? _____
  - How long? _____
- Do you sleep well? _____
- Do you snore? _____
- Are you sleepy during the day, or do you require a nap? _____
- Ever fall asleep while driving? _____

11) Are there any issues that you feel are important and were missed?

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Thank you for completing this form. It greatly improves our ability to understand and manage your condition. **Thank you.**