Mountain Kidney & Hypertension Associates

Renal Disease Assessment

Name: _____

Chief Complaint: _____

_____

Family History: Age if living/Illness Age and Cause of Death

Father _____ _____

Mother _____ _____

Brother/Sister _____ _____

Children _____ _____

Check if Immediate Blood Relative has/had: [ ] Kidney Disease [ ] Kidney Stones

[ ]Heart Disease [ ]Stroke [ ]High Blood Pressure [ ] Cancer

Social History (Family support)

-Marital Status: Single Married Divorced Widower

-Number of Children: _____ Number living with you:_____

-Do you currently receive Home Health Care: _____Y _____N

Education and Employment:

-Highest education completed: _____

-Employed at present, if so where: _____

-Retired or Disabled: Y N If yes, date: ____/_____/_____

-Current/past jobs: _____

_____

-Work Schedule: _____

-Is travel required with your current job? YES NO

-Is lifting 20lbs or more required for your current job? YES NO

Transportation:

-Do you drive: Yes No

-Do you need assistance with transport to the doctors' office? Yes No

CIGARETTE USE-PAST AND PRESENT: Yes No # of years & packs/day? _____

Other Tobacco use (cigars, snuff, etc) Yes No

Alcohol use: Yes No If yes, how much and how often?_____

Your Usual Weight: _____lbs. Height: _____ft. _____in.

Allergies: Yes No List: _____

Review of Systems: (Do you have or have had any of the following health problems?

NEPHROLOGY/UROLOGY (Kidney/Urinary Tract/Bladder) DISORDERS

Swollen ankles or feet	Yes	No	
Abnormal urination	Yes	No	
Kidney Insufficiency/Failure	Yes	No	
Protein/Blood in Urine	Yes	No	Which:_____
Kidney Stones	Yes	No	
Frequent Urinary Tract Infections	Yes	No	
Prostate Enlargement/Cancer	Yes	No	Which:_____

Other: _____

Pulmonary (Lung/Breathing) DISORDERS

Shortness of Breath	Yes	No	
COPD/Bronchitis/Emphysema	Yes	No	Which: _____
Asthma	Yes	No	
Coughing up blood	Yes	No	

Other: _____

CARDIOVASCULAR (Heart/Artery/Blood Vessel) DISORDERS

High Blood Pressure	Yes	No	
Heart Attack	Yes	No	
Chest Pain	Yes	No	
Heart Failure	Yes	No	
Circulation Problems	Yes	No	
Palpitations (abnormal heart beats/rhythm)	Yes	No	
Previous stress test	Yes	No	When: _____

GASTROINTESTINAL (Stomach/Liver/Gallbladder/Pancreas/Intestinal/Colon) DISORDERS

Poor Appetite	Yes	No	
Nausea/Vomiting	Yes	No	Which: _____
Gastritis/reflux	Yes	No	Which: _____
Abdominal Pain	Yes	No	
Diarrhea/Constipation	Yes	No	Which: _____
Liver Disease/Hepatitis	Yes	No	Which: _____
Prior Colonoscopy	Yes	No	When: _____

Other: _____

NEUROLOGIC (Brain/Nervous System/Spinal) DISORDERS

Vision problems	Yes	No	
Hearing problems	Yes	No	
Stroke/TIA	Yes	No	

Other: _____

ENDOCRINE (Gland/Hormone) DISORDERS

Diabetes	Yes	No	
High Cholesterol	Yes	No	
Thyroid Disease	Yes	No	
Postmenopausal (no periods)	Yes	No	Year: _____

Other: _____

SLEEP PROBLEMS:

Snoring	Yes	No
Breathing stops/pauses while asleep	Yes	No
Jerking/involuntary movement of arms/legs	Yes	No
Falling asleep easily during day	Yes	No
Insomnia (can't fall asleep/can't stay asleep)	Yes	No

Other: _____

MUSCULOSKELETAL (Bone/Muscle/Joint) DISORDERS

Amputations/Prosthesis	Yes	No	Location:_____
Arthritis/Gout	Yes	No	
Osteoporosis	Yes	No	

Other: _____

HEMATOLOGY/ONCOLOGY (Blood/Cancer) DISORDERS

Anemia (low blood)	Yes	No	
Cancer	Yes	No	Describe: _____
Previous blood transfusion/s	Yes	No	
Blood Clots	Yes	No	

SKIN DISORDERS

Rash/Itching	Yes	No	Location: _____

Other: _____

VACCINATIONS

Flu Vaccine	Yes	No	DATE:_____
Pneumovax	Yes	No	DATE:_____
Hepatitis Vaccine	Yes	No	DATE:_____

OTHER MEDICAL DISORDERS/ILLNESSES_____

_____

I have personally reviewed this system review with Mr/Mrs. _____

MD:_____DATE: _____