REDWOOD RENAL ASSOCIATES

Name: *(Last, First, M.I.)* ☐ M ☐ F	**DOB:**

PAST MEDICAL HISTORY – COMMON DISEASES

Do you have a personal history of any of the following?

Kidney Disease	☐ CKD Stage: 1 2 3 4 5 ☐ Transplant ☐ Cadaveric ☐ Living - Related ☐ Living - Unrelated	☐ Dialysis ☐ HD ☐ PD ☐ Polycystic Kidney Disease ☐ Acute Kidney Injury ☐ Glomerulonephritis
Diabetes	☐ Type 1 ☐ Type 2	☐ Type Unknown
High Blood Pressure	☐ Essential ☐ Renovascular	☐ White Coat Hypertension ☐ Conn's Syndrome
Ischemic Heart Disease	☐ Heart attack ☐ Angina ☐ Angioplasty	☐ Coronary Stent ☐ CABG (Coronary Artery Bypass Graft)
Cancer	☐ Lung ☐ Breast ☐ Prostate (male) ☐ Colon ☐ Melanoma ☐ Bladder	☐ Lymphoma ☐ Kidney ☐ Thyroid ☐ Leukemia ☐ Endometrial (female) ☐ Pancreatic
Stroke	☐ Stroke	
Gout	☐ Gout	

PAST MEDICAL HISTORY – ADDITIONAL CONDITIONS

Do you have a personal history of any of the following?

EENT	☐ Blindness ☐ Cataracts	☐ Hearing Problems ☐ Glaucoma
Cardiovascular	☐ Atrial Fibrillation ☐ Pacemaker ☐ High Cholesterol	☐ AICD (Cardiac Defibrillator) ☐ Valvular Heart Disease ☐ Congestive Heart Failure ☐ Mitral Valve Prolapse
Respiratory	☐ COPD ☐ Chronic Bronchitis ☐ Asthma ☐ Emphysema	☐ Pneumonia ☐ Tuberculosis ☐ Sleep Apnea

Gastrointestinal	☐ GERD (Gastric Reflux) ☐ Stomach/Bowel Ulcers ☐ Gall Bladder Disease ☐ Hepatitis	☐ Inflammatory Bowel Disease ☐ Irritable Bowel Syndrome ☐ Gluten Intolerance ☐ Lactose Intolerance
Genitourinary	☐ Enlarged Prostate(male) ☐ Kidney Stones	☐ Frequent UTIs (Urinary Tract Infections)
OB History	☐ Preeclampsia (female) ☐ Pregnancy Induced Hypertension (female)	☐ Gestational Diabetes (female) ☐ History of Complicated Pregnancy (female)
Musculoskeletal	☐ Osteoarthritis	☐ Osteoporosis
Neurological	☐ Multiple Sclerosis ☐ Seizures	☐ Parkinson's ☐ Dementia
Psychiatric	☐ Depression	☐ Anxiety Disorder
Endocrine	☐ Hypothyroidism ☐ Hyperparathyroidism	☐ Hyperthyroidism ☐ Adrenal Insufficiency
Hematology	☐ Anemia ☐ Sickle Cell Disease	☐ Sickle Cell Trait ☐ Blood Transfusion ☐ Thalassemia
Immuno/Allergy	☐ HIV ☐ AIDS	☐ Rheumatoid Arthritis ☐ Lupus

PAST MEDICAL HISTORY – SURGERY HISTORY

Have any of the following surgeries been performed on you?

☐ Appendectomy	☐ Hip Replacement	☐ Renal Transplant
☐ CABG	☐ Left ☐ Bilateral	☐ Thyroidectomy
☐ Carotid Endarterectomy	☐ Right	☐ Tonsillectomy
☐ Cataract Surgery	☐ Knee Replacement	☐ Valve Replacement
☐ D & C (female)	☐ Left ☐ Bilateral	☐ AV Fistula
☐ Gall Bladder Removal	☐ Right	☐ AV Graft
☐ Gastric Bypass	☐ Hysterectomy (female)	☐ PD Catheter
☐ Hemorrhoidectomy	☐ Prostatectomy (male)	☐ Other_____
☐ Hernia Repair	☐ Nephrectomy	

Other Health Problems Not Listed Above:

FAMILY HISTORY – ILLNESSES

Do the following family members have any of the following medical conditions?

Kidney Disease	☐ Father ☐ Mother	☐ Sibling ☐ Child
Diabetes	☐ Father ☐ Mother	☐ Sibling ☐ Child
High Blood Pressure	☐ Father ☐ Mother	☐ Sibling ☐ Child
Ischemic Heart Disease	☐ Father ☐ Mother	☐ Sibling ☐ Child
Cancer	☐ Father ☐ Mother	☐ Sibling ☐ Child
Stroke	☐ Father ☐ Mother	☐ Sibling ☐ Child
Gout	☐ Father ☐ Mother	☐ Sibling ☐ Child
ADPKD	☐ Father ☐ Mother	☐ Sibling ☐ Child
Dementia	☐ Father ☐ Mother	☐ Sibling ☐ Child

FAMILY HISTORY – STATUS

Father	☐ Living ☐ Unknown	☐ Deceased ☐ Age at Death:_____ ☐ Cause of Death:_____
Mother	☐ Living ☐ Unknown	☐ Deceased ☐ Age at Death:_____ ☐ Cause of Death:_____

Other Family History Not Listed Above:

SOCIAL HISTORY – GENERAL

Current Marital Status	☐ Married ☐ Separated ☐ Single	☐ Widowed ☐ Divorced
Living Arrangement	☐ Alone ☐ Family Member ☐ Spouse	☐ In Home Caregiver ☐ Significant Other ☐ Assisted Living Facility

Occupation	☐ Retired
	☐ Unemployed
	☐ Employed
	  ☐ Full - time
	  ☐ Part - time
	☐ Student
	
	List your Current or Former Occupation:_____	

Functional/ Cognitive	☐ No Impairment ☐ Hearing Loss ☐ Limited Mobility	☐ Memory Deficit ☐ Poor Vision or Blindness ☐ Transportation Challenges

SOCIAL HISTORY – HABITS

Tobacco Use	☐ Current or Former User
	  ☐ Cigarettes
	  ☐ Chewing Tobacco
	  ☐ Pipes
	  ☐ Snuff
	  ☐ Cigars
	
	If a former user, what year did you quit?
	_____
		☐ Never Used
		☐ Unknown

	Complete the following section if you are a current or former cigarette user: How often do you currently smoke or how often did you smoke before you quit? ☐ Every Day ☐ Some Days ☐ Unknown How many packs per day do you currently smoke or how many packs per day did you smoke before you quit? _____ How many total years have you used cigarettes? _____
Alcohol Use	☐ Current or Former User ☐ Never Used ☐ Occasional/Social ☐ 1-2 per Day ☐ 3 or more per Day If a former user, what year did you quit? _____
Recreational Drug Use	☐ Current or Former User ☐ Marijuana ☐ Amphetamines ☐ LSD ☐ Heroin ☐ Ecstasy ☐ Never Used If a former user, what year did you quit? _____ ☐ Opium ☐ Cocaine ☐ Barbiturates ☐ Other _____

Other Social History Not Listed Above:

REVIEW OF SYSTEMS

Constitutional	☐ Fever ☐ Weight Gain ☐ Weight Loss	☐ Fatigue ☐ Chills ☐ Weakness
HEENT	☐ Vision Impaired ☐ Eye Pain ☐ Redness ☐ Color Blindness ☐ Double Vision ☐ Hearing Loss ☐ Ear Pain	☐ Sinus Problems ☐ Sore Throat ☐ Nose Bleeds ☐ Headache ☐ Hoarseness ☐ Tinnitus ☐ Vertigo
Respiratory	☐ Shortness of Breath ☐ At Rest ☐ With Activity ☐ Pain with Breathing	☐ Cough ☐ Wheezing ☐ Blood in Sputum ☐ Night Sweats
Cardiovascular	☐ Chest Pain ☐ Palpitations ☐ Claudication	☐ Orthopnea ☐ Edema ☐ PND (Paroxysmal Nocturnal Dyspnea)
Gastrointestinal	☐ Abdominal Pain ☐ Nausea ☐ Diarrhea ☐ Heartburn ☐ Vomiting	☐ Constipation ☐ Anorexia ☐ Trouble Swallowing ☐ Indigestion
Genitourinary	☐ Urinary Urgency ☐ Urinary Burning or Pain ☐ Blood in Urine ☐ Urinary Frequency	☐ Urinary Hesitancy ☐ Foamy Urine ☐ Incontinence ☐ Nocturia
Musculoskeletal	☐ Back Pain ☐ Neck Pain ☐ Joint Pain ☐ Muscle Pain ☐ Arm Weakness ☐ Left ☐ Right ☐ Both	☐ Leg Weakness ☐ Left ☐ Right ☐ Both
Skin	☐ Rash ☐ Itching ☐ Scaling	☐ Dryness ☐ Color Change

Neurological	☐ Numbness ☐ Tremors ☐ Seizures	☐ Tingling ☐ Fainting
Psychiatric	☐ Depression ☐ Insomnia	☐ Anxiety
Endocrine	☐ Heat Intolerance ☐ Cold Intolerance	☐ Excessive Thirst ☐ Excessive Urination
Hematology	☐ Bleeding Gums	☐ Easy Bruising
Immuno/Allergy	☐ Seasonal Allergies	☐ Hives

Other Review of Systems Not Listed Above: