SNOWY RANGE KIDNEY CARE

Patient Name:_____

Date of Birth:_____/_____/_____

Why are we seeing you?_____

_____

_____

List allergies and state reaction, if known. Circle, 'none', if you have no allergies.

_____

_____

_____

Medications you are taking (include, all prescriptions, OTC meds, vitamins, herbals)

Medication Name Dose (mg, mcg, ml, etc) How Often?(daily, twice daily, etc)

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Family History: Please list <u>family members</u> with following health issues: (paternal/maternal)

- Kidney disease: _____
- High blood pressure:_____
- Diabetes:_____
- Cardiovascular disease:_____
- Stroke:_____
- Cancer(type, if known):_____
- Auto-immune disease (eg lupus, rheumatoid arthritis)_____
- Other:_____

Past Surgical History- Please list any surgeries/procedures you have had and estimated date

_____

_____

_____

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Diet and Exercise

What type of diet are you following (such as low salt, diabetic, regular?) _____
Do you have any dietary restrictions? _____
What is your exercise level? None Occasional Moderate Heavy

Education and Occupation

Are you currently employed? _____
What is your occupation? _____

Activities of Daily Living

Are you able to care for yourself? Yes No
Are you blind or do you have difficulty seeing? Yes No
Are you deaf or do you have serious difficulty hearing? Yes No
Do you have difficulty concentrating, remembering or making decisions? Yes No
Do you have difficulty walking or climbing stairs? Yes No
Do you have transportation difficulties? Yes No

Substance Use

Do you or have you ever smoked tobacco?: Never Former Use Current Use
How many years have you smoked tobacco? _____
How many packs per day? _____ When did you quit smoking? _____
Do you or have you ever used any other forms of tobacco or nicotine? Yes No
Do you or have you ever used vape or e-Cigarettes? Never Former Use Current Use
What was the date of your most recent tobacco screening? _____
Have you been counseled for smoking cessation? Yes No
Do you or have you ever used smokeless tobacco?: Never Former Use Current Use
What is your level of alcohol use? None Occasional Moderate* Heavy*

*Moderate = Men: 2 or more drinks per day; Women 1 or more per day
*Heavy = Men: 4 or more drinks on any day or more than 14 per week; Women 3 or more drinks on any day or more than 7 per week)

How many years have you consumed alcohol? _____
Have you ever been counseled for unhealthy alcohol use? Yes No
Do you use any illicit or recreational drugs? Yes No
What is your level of caffeine consumption? None Occasional Moderate Heavy

Marriage and Sexuality

What is your relationship status? Married Single Divorced Widowed Domestic Partner Other
How many children do you have? _____

Public Health and Travel

Have you recently traveled abroad? Yes No
Have you been to an area known to be high risk for COVID? Yes No
Have you been around anyone with COVID in the past 14 days? Yes No

Advanced Directive

Do you have an advance directive? Yes No

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Past Medical History

Yes No Kidney disease _____
Yes No Kidney Transplant_____
Yes No Other Organ Transplant_____
Yes No Kidney stone _____
Yes No Kidney infection_____
Yes No Prostate Enlargement (BPH) _____
Yes No Hypertension _____
Yes No Coronary artery disease _____
Yes No Congestive heart failure _____
Yes No Heart disease _____
Yes No Atrial fibrillation_____
Yes No Abdominal Aortic Aneurysm _____
Yes No Peripheral Vascular Disease _____
Yes No Stroke/Mini Stroke_____
Yes No High cholesterol_____
Yes No Diabetes_____
Yes No Thyroid disease _____
Yes No Electrolyte Imbalance_____
Yes No Emphysema/COPD_____
Yes No Asthma_____
Yes No Sleep Apnea_____
Yes No Cancer (specify)_____
Yes No Anemia/Low Blood Count _____
Yes No Blood transfusion_____
Yes No Blood clots legs or lungs_____
Yes No Lupus or Auto-immune_____
Yes No Arthritis_____
Yes No Gout_____
Yes No Acid Reflux (GERD)_____
Yes No Liver disease (hepatitis)_____
Yes No HIV infection _____
Yes No Infectious Disease/COVID_____
Yes No Seizure/Epilepsy_____
Yes No Depression_____

Other medical history not listed above: _____
_____
_____

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Review of Systems: Circle any conditions you have experienced in the past month

Renal/Urinary: Blood in urine/cola colored urine, Protein in urine, Difficulty urinating, Increased urine production, Pain during urination, Incontinence

Constitutional: Fever, Chills, New weight loss (____pounds), Loss of energy, Loss of Appetite, Frequent headaches

Eyes: Blurred vision, Double vision, Eye Pain/irritation, Vision Change, Loss of Vision

Ears/Nose/Mouth: Sinus problems, Nosebleeds, Sore throat, Mouth sores

Heart: Chest pain/discomfort, Ankle or leg swelling, Calf pain with walking

Lungs: Frequent coughing, Trouble breathing/short of breath, Shortness of breath when walking, Shortness of breath when lying down

Stomach: Stomach pain, Frequent nausea, Frequent vomiting, Frequent diarrhea, Frequent heartburn or indigestion

Muscles and Bones: Joint pain, Frequent muscle aches, Swelling in the arms or legs, Swelling in the joints, Recent broken bones or fractures

Skin: Rash, Persistent itching

Neurologic: Recent changes or loss of memory, numbness or tingling in hands/feet, recent pain in hands/feet

Endocrine: Extreme tiredness, Extreme intolerance to cold or hot, excessive thirst/fluid intake

Hematologic/Lymphatic: Swollen glands, blood clotting problems

Mental Wellness: Lack of interest in life activities, Feeling depressed, Extreme anxiety

Describe any other new concern you want your provider to know: _____

_____

_____