

Please complete before your first appointment. Bring your medication list and insurance card.

PATIENT INFORMATION

Name: DOB: Date:
Phone: Email:
Primary Care Provider: Referring Provider:
Preferred Pharmacy: Location:

REASON FOR VISIT / KIDNEY HISTORY

Main reason for today's visit:

Have you seen a kidney specialist before? ☐ No ☐ Yes

Kidney history - check all that apply:

☐ Chronic kidney disease ☐ Kidney stones ☐ Protein in urine ☐ Blood in urine ☐ Recurrent UTI ☐ Kidney biopsy ☐ Kidney surgery
☐ Dialysis ☐ Kidney transplant ☐ None

Family history of kidney disease/dialysis? ☐ No ☐ Yes

MEDICAL HISTORY

☐ High blood pressure ☐ Diabetes ☐ Heart disease ☐ Heart failure ☐ Atrial fibrillation ☐ Stroke/TIA ☐ High cholesterol ☐ Gout
☐ Autoimmune disease/lupus ☐ Liver disease ☐ Lung disease/COPD ☐ Sleep apnea ☐ Cancer ☐ Anemia ☐ Thyroid disease
☐ Enlarged prostate/urinary problems

Other significant conditions:

Recent hospitalization (past 12 months)? ☐ No ☐ Yes - reason:

CURRENT KIDNEY-RELATED SYMPTOMS

☐ Leg/ankle swelling ☐ Shortness of breath ☐ Weight gain ☐ Decreased urine ☐ Frequent/nighttime urination ☐ Difficulty urinating
☐ Burning with urination ☐ Blood in urine ☐ Foamy urine ☐ Flank/back pain ☐ Nausea/vomiting ☐ Poor appetite ☐ Fatigue
☐ Itching ☐ None

MEDICATIONS

Please handwritten all prescription medicines, over-the-counter medicines, vitamins and supplements below - or attach a current medication list.

☐ Regular NSAID use (Advil/Motrin/Aleve)? ☐ No ☐ Yes

☐ Herbal / protein / creatine supplements? ☐ No ☐ Yes

ALLERGIES

☐ No known drug allergiesMedication/substance: Reaction: Medication/substance: Reaction:

SURGICAL HISTORY

Major surgeries / approximate dates:

SOCIAL HISTORY

Tobacco: ☐ Never ☐ Current ☐ Former Amount/years: Alcohol: ☐ None ☐ Occasional ☐ Regular Approx. drinks/week: Recreational drugs: ☐ No ☐ Yes If yes: Occupation:

ADDITIONAL INFORMATION / QUESTIONS FOR YOUR KIDNEY DOCTOR

PATIENT ACKNOWLEDGMENT

I certify that the information provided is accurate to the best of my knowledge and will notify the practice of important changes to my medications, allergies, or medical history.

Patient/Representative Name: Signature: Date: