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NEW PATIENT EVALUATION

Please fill out this form as accurately as possible.

Name: ____

DOB: ____

Do you have: Please circle

Known Kidney Disease:	YES	NO
Urination at night:	YES	NO
Frequent urination:	YES	NO
Burning on urination:	YES	NO
Protein/Foamy Urine:	YES	NO
Blood in urine:	YES	NO
Kidney Stone:	YES	NO
Diabetes in Eyes:	YES	NO
Diabetes in Nerves:	YES	NO
Pain in Walking:	YES	NO
Kidney/bladder infection:	YES	NO
Herbal Medicine:	YES	NO
Childhood Nephritis:	YES	NO
Consistent use of Non-Steroidal:	YES	NO

List Medical Problems With Approximate Year when Diagnosed:

1. ____
2. ____
3. ____
4. ____
5. ____

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Please List Medicines Including Over-the-Counter Medicines and bring them along to your visit:

1. ____
2. ____
3. ____
4. ____
5. ____
6. ____
7. ____
8. ____
9. ____
10. ____

Allergies and Type of Reaction:

____

____

Family History

Kidney Disease:	YES	NO	Diabetes:	YES	NO
Heart Attack:	YES	NO	Cancer:	YES	NO
High Blood Pressure:	YES	NO	Stroke:	YES	NO
Gout:	YES	NO	Lupus:	YES	NO
Kidney Transplant:	YES	NO	Dialysis:	YES	NO

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Social History:

Smoked:	YES	NO	Packs Per Day: ___________	How Many Years: _________
Alcohol:	YES	NO	Drinks Per Day: ___________	How Many Years: _________

Review of Symptoms: Circle any that Regularly Occur

General:

Fatigue:	YES	NO
Chills:	YES	NO
Change in Appetite:	YES	NO
Trouble Lying Flat:	YES	NO
Heart Attack:	YES	NO
Irregular Heart Beat:	YES	NO
Change in Weight:	YES	NO
Excessive Water Drinking:	YES	NO
Thyroid Disease:	YES	NO
Night Sweats:	YES	NO
Chest Pain/Tightness:	YES	NO
Fever:	YES	NO
Murmur:	YES	NO
Hot/Cold Sensitivity:	YES	NO

HEENT:

Diverticuli/Hemmorhoids:	YES	NO
Diarrhea:	YES	NO
Ringing in Ears:	YES	NO
Blood Transfusion:	YES	NO
Frequent Sore Throats:	YES	NO
Black Tarry Stool:	YES	NO
Anemia:	YES	NO
Loss of Consciousness:	YES	NO
Blurry Vision:	YES	NO
Hayfever/Sinusitus:	YES	NO
Liver Disease/Hepatitis:	YES	NO
Blood in Stool:	YES	NO
Ulcers:	YES	NO
Easy Bruising:	YES	NO
Double Vision:	YES	NO
NoseBleeds:	YES	NO
Blood Clot:	YES	NO
Constipation:	YES	NO
Vomiting Blood:	YES	NO
Hoarseness:	YES	NO
Trouble Swallowing:	YES	NO
Migraine:	YES	NO

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Joint:

Swollen Joints:	YES	NO
Back Pain:	YES	NO
Weakness:	YES	NO
Muscle Pain:	YES	NO
Arthritis:	YES	NO
Rashes:	YES	NO
Osteoporosis:	YES	NO

Pulmonary:

Asthma:	YES	NO
Coughing up Blood:	YES	NO
Asbestos/Silica Contact:	YES	NO
Tuberculosis:	YES	NO
Unresolving Pneumonia:	YES	NO
Wheezing:	YES	NO
Shortness of Breath with Exercise:	YES	NO
Persistent Cough:	YES	NO

Neurologic

Siezures:	YES	NO
Loss of Balance:	YES	NO
Numbness:	YES	NO
Psychologic Treatment:	YES	NO
Stroke:	YES	NO
Vertigo:	YES	NO

Others: ____________________________________

____

____

____

____

____

____

Primary Care Physician: ____

Referring Physician: ____

Any other Physicians in the last year: ____________________________________

____

____

____