KSM
KIDNEY SPECIALISTS
OF MINNESOTA

Patient Name: ________________________ Date of Birth: _____/_______/________

Today's Date: _____/_______/_________ Date of Appointment: __/______/______

Please complete below and return to Kidney Specialists of MN in the enclosed stamped envelope at least 7 days prior to your appointment.

	Do You Have A Personal History of. . .				
Acute Kidney Injury	Yes/No	GERD	Yes/No	Lupus	Yes/No
Anemia	Yes/No	Gout	Yes/No	Myocardial Infarction	Yes/No
Atrial Fibrillation	Yes/No	Hepatitis B	Yes/No	Nephrotic Syndrome	Yes/No
Cancer	Yes/No	Hepatitis C	Yes/No	Osteoarthritis	Yes/No
CHF	Yes/No	HIV/AIDS	Yes/No	Osteoporosis	Yes/No
Chronic Kidney disease	Yes/No	Hyperkalemia	Yes/No	Polycystic Kidney	Yes/No
Clotting disorder	Yes/No	Hyperlipidemia	Yes/No	Pyelonephritis	Yes/No
COPD	Yes/No	Hyperparathyroidism	Yes/No	Renal Cyst	Yes/No
Coronary Artery Disease	Yes/No	Hypertension	Yes/No	Sleep Apnea	Yes/No
Diabetes Mellitus	Yes/No	Hyponatremia	Yes/No	Stroke	Yes/No
Diabetic Nephropathy	Yes/No	Hypothyroidism	Yes/No	TIA	Yes/No
ESRD	Yes/No	Kidney Stones	Yes/No	UTI (Frequent)	Yes/No

Surgery History					
Abdomen Surgery	Yes/No	Hysterectomy	Yes/No	-Living relative Donor	Yes/No
Bladder Surgery	Yes/No	Kidney Biopsy	Yes/No	-Living unrelated donor	Yes/No
CABG	Yes/No	Kidney Removal	Yes/No	Lithotripsy	Yes/No
Cardiac Stent	Yes/No	Kidney Stone	Yes/No	Parathyroid Surgery	Yes/No
Dialysis Access	Yes/No	Kidney Transplant Recipient:	Yes/No	Thyroid Surgery	Yes/No
Gallbladder Surgery	Yes/No	-Deceased Donor	Yes/No	Other-	Yes/No

Family History	**Please select all that apply:**
Mother: Living/Deceased	☐ Anemia ☐ Autoimmune Disease ☐ Cancer ☐ Diabetes ☐ Hypertension ☐ Kidney Disease ☐ Stroke ☐ Heart Disease ☐ Dementia ☐ Gout ☐ Autosomal Dominance ☐ No Known Problems
Father: Living/Deceased	☐ Anemia ☐ Autoimmune Disease ☐ Cancer ☐ Diabetes ☐ Hypertension ☐ Kidney Disease ☐ Stroke ☐ Heart Disease ☐ Dementia ☐ Gout ☐ Autosomal Dominance ☐ No Known Problems
Sister: Living/Deceased/NA	☐ Anemia ☐ Autoimmune Disease ☐ Cancer ☐ Diabetes ☐ Hypertension ☐ Kidney Disease ☐ Stroke ☐ Heart Disease ☐ Dementia ☐ Gout ☐ Autosomal Dominance ☐ No Known Problems
Brother: Living/Deceased/NA	☐ Anemia ☐ Autoimmune Disease ☐ Cancer ☐ Diabetes ☐ Hypertension ☐ Kidney Disease ☐ Stroke ☐ Heart Disease ☐ Dementia ☐ Gout ☐ Autosomal Dominance ☐ No Known Problems

Maternal Aunt: Living/Deceased/NA	☐ Anemia ☐ Autoimmune Disease ☐ Cancer ☐ Diabetes ☐ Hypertension ☐ Kidney Disease ☐ Stroke ☐ Heart Disease ☐ Dementia ☐ Gout ☐ Autosomal Dominance ☐ No Known Problems
Maternal Uncle: Living/Deceased/NA	☐ Anemia ☐ Autoimmune Disease ☐ Cancer ☐ Diabetes ☐ Hypertension ☐ Kidney Disease ☐ Stroke ☐ Heart Disease ☐ Dementia ☐ Gout ☐ Autosomal Dominance ☐ No Known Problems
Paternal Aunt Living/Deceased/NA	☐ Anemia ☐ Autoimmune Disease ☐ Cancer ☐ Diabetes ☐ Hypertension ☐ Kidney Disease ☐ Stroke ☐ Heart Disease ☐ Dementia ☐ Gout ☐ Autosomal Dominance ☐ No Known Problems
Paternal Uncle: Living/Deceased/NA	☐ Anemia ☐ Autoimmune Disease ☐ Cancer ☐ Diabetes ☐ Hypertension ☐ Kidney Disease ☐ Stroke ☐ Heart Disease ☐ Dementia ☐ Gout ☐ Autosomal Dominance ☐ No Known Problems
Maternal Grandmother Living/Deceased	☐ Anemia ☐ Autoimmune Disease ☐ Cancer ☐ Diabetes ☐ Hypertension ☐ Kidney Disease ☐ Stroke ☐ Heart Disease ☐ Dementia ☐ Gout ☐ Autosomal Dominance ☐ No Known Problems
Maternal Grandfather Living/Deceased	☐ Anemia ☐ Autoimmune Disease ☐ Cancer ☐ Diabetes ☐ Hypertension ☐ Kidney Disease ☐ Stroke ☐ Heart Disease ☐ Dementia ☐ Gout ☐ Autosomal Dominance ☐ No Known Problems
Paternal Grandmother Living/Deceased	☐ Anemia ☐ Autoimmune Disease ☐ Cancer ☐ Diabetes ☐ Hypertension ☐ Kidney Disease ☐ Stroke ☐ Heart Disease ☐ Dementia ☐ Gout ☐ Autosomal Dominance ☐ No Known Problems
Paternal Grandfather Living/Deceased	☐ Anemia ☐ Autoimmune Disease ☐ Cancer ☐ Diabetes ☐ Hypertension ☐ Kidney Disease ☐ Stroke ☐ Heart Disease ☐ Dementia ☐ Gout ☐ Autosomal Dominance ☐ No Known Problems

Review of Systems (Areas of Concern)	**Please circle if this is a concern for you (leave blank if not applicable):**

Constitution	Fever Chills Weight loss Malaise/Fatigue Diaphoresis Weakness
Skin	Rash Itching
HENT (Head/Ear/Nose/Throat)	Hearing Loss Tinnitus Ear Pain Ear Discharge Nosebleeds Congestions Stridor Sore Throat
Eyes	Blurred vision Double Vision Photophobia Eye pain Eye discharge Eye Redness
Cardiovascular	Chest Pain Palpitations Orthopnea Claudication Leg Swelling
Respiratory	Cough Hemoptysis Sputum Production Shortness of Breath Wheezing
Gastrointestinal	Heartburn Nausea/Vomiting Abdominal Pain Diarrhea Blood in stool Melena
GU (Genitourinary)	Dysuria Urgency Frequency Hematuria Flank Pain
Musculoskeletal	Myalgias Neck Pain Back Pain Joint Pain Falls Other
Endo/Heme/Aller	Easy Bruise/bleeding Environmental Allergies Polydipsia
Neurological	Dizziness Headaches Tingling Tremor Sensory Changes Speech Changes Focal weakness Seizures Other____________
Psychiatric	Depression Suicidal Ideas Substance abuse Hallucinations Nervous/Anxious Insomnia Memory Loss Other ___________

TOBACCO USER	Tobacco Use Current/Former/Never	Smokeless Tobacco Current/Former/Never
	Start Date	**Start Date**
	Quit Date	**Quit Date**
	Type Cigarettes/Pipe/Cigars	**Type** Chew/Snuff
	Packs per day	
	Years smoked	

ALCOHOL USE	**Alcohol Use** Yes, Not Currently, Never, Deferred
	Drinks per Week ____Glasses of Wine ____Cans of Beer ____Shots of Liquor ____Standard Drinks or equivalent
	Alcohol per Week Total____
Substance Use	**Drug Use** Yes, Not Currently, Never, Deferred **Types** **Use per Week**

SOCIAL HISTORY—STATUS	DETAILS	
LIVING ARRANGEMENTS	**Lives Alone**	
	Spouse	
	Significant Other	
	Family Memer	
	In Home Caregiver	
	Assisted Living Facility	
Functional/Cognitive	Impairment	Yes/No
	Memory Deficit	Yes/No
	Hearing Loss	Yes/No
	Poor Vision or Blindness	Yes/No
	Limited Mobility	Yes/No
	Transportation Challenges	Yes/No

CURRENT MEDICATIONS
(INCLUDING OVER-THE-COUNTER AND HERBAL MEDICATIONS)

Please **bring all medication bottles to your appointment (preferred**), or list your current medications below, or attach a current list of medications.

NAME	DOSE	FREQUENCY (HOW OFTEN DO YOU TAKE?)

Are you allergic or intolerant to any medications? ☐ **NO** ☐ **Yes, please list below:**

MEDICATION	ALLERGY	INTOLERANCE	REACTION