

THE UNIVERSITY OF KANSAS PHYSICIANS

Department of Internal Medicine – Nephrology

Welcome to our practice. As a new patient, we will discuss your health in detail. To help in these discussions, please fill out the information below to the best of your ability.

Name: _____

KUMC #: _____

Date: _____ DOB: _____

Primary Care Doctor: _____ Phone: () _____ Address: _____

Referring Doctor: _____ Phone: () _____ Address: _____

Reason for Visit:

Medical History:

Patient medical history:

Diabetes	Yes	No
Hypertension	Yes	No
Cancer	Yes	No
Stroke	Yes	No
Heart Trouble	Yes	No
Arthritis/Gout	Yes	No
Convulsions	Yes	No
Bleeding tendency	Yes	No
Acute infections	Yes	No
Sexual disease	Yes	No
Birth defects	Yes	No
Thyroid problems	Yes	No
Osteoporosis	Yes	No
Vision problems	Yes	No
Hearing problems	Yes	No
Ulcers	Yes	No
Stomach problems	Yes	No
Back pain	Yes	No
Other		

Previous Hospitalizations/Surgeries/Serious Injuries

When?

Medications:

Allergies:

Patient social history:

Marital status: Single: _____ Married: _____ Separated: _____ Divorced: _____ Widowed: _____

Use of alcohol: Never: _____ Rarely: _____ Moderate: _____ Daily: _____

Use of tobacco: Never: _____ Previously, but quit _____ Current packs/day: _____

Use of drugs: Never: _____ Type/frequency: _____

Excessive exposure at home or work to: Fumes: _____ Dust: _____ Solvents: _____ Airborne Particles: _____ Noise: _____

Occupation/work environment: _____

Do you have a living will or advance directive? Yes No

Family medical history:

	Age	Diseases	If deceased, cause of death
Mother	_____	_____	_____
Father	_____	_____	_____
Siblings	_____	_____	_____
Spouse	_____	_____	_____
Children	_____	_____	_____

Review of Systems. Please check the symptoms you are **currently** experiencing.

CONSTITUTION	EYES	ENDOCRINE	ALLERGY/IMMUNOLOGY
<input type="checkbox"/> Activity change	<input type="checkbox"/> Eye discharge	<input type="checkbox"/> Cold intolerance	<input type="checkbox"/> Environmental allergies
<input type="checkbox"/> Appetite change	<input type="checkbox"/> Eye itching	<input type="checkbox"/> Heat intolerance	<input type="checkbox"/> Food allergies
<input type="checkbox"/> Chills	<input type="checkbox"/> Eye pain	<input type="checkbox"/> Excessive thirst (Polydipsia)	<input type="checkbox"/> Immunocompromised
<input type="checkbox"/> Diaphoresis (Sweating)	<input type="checkbox"/> Eye redness	<input type="checkbox"/> Increased appetite (Polyphagia)	NEUROLOGICAL
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Sensitivity to light (Photophobia)	<input type="checkbox"/> Excessive urination volume (Polyuria)	<input type="checkbox"/> Dizziness
<input type="checkbox"/> Fever	<input type="checkbox"/> Visual disturbances	GENITOURINARY	<input type="checkbox"/> Facial asymmetry
<input type="checkbox"/> Unexpected weight change	RESPIRATORY	<input type="checkbox"/> Difficulty urinating	<input type="checkbox"/> Headaches
HEAD/ENT	<input type="checkbox"/> Apnea	<input type="checkbox"/> Painful intercourse (Dyspareunia)	<input type="checkbox"/> Light-headedness
<input type="checkbox"/> Congestion	<input type="checkbox"/> Chest tightness	<input type="checkbox"/> Painful urination (Dysuria)	<input type="checkbox"/> Numbness
<input type="checkbox"/> Dental problem	<input type="checkbox"/> Choking	<input type="checkbox"/> Incontinence (Enuresis)	<input type="checkbox"/> Seizures
<input type="checkbox"/> Drooling	<input type="checkbox"/> Cough	<input type="checkbox"/> Flank pain	<input type="checkbox"/> Speech difficulty
<input type="checkbox"/> Ear discharge	<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Frequency	<input type="checkbox"/> Fainting (Syncope)
<input type="checkbox"/> Ear pain	<input type="checkbox"/> Inhale wheeze (Stridor)	<input type="checkbox"/> Genital sore	<input type="checkbox"/> Tremors
<input type="checkbox"/> Facial swelling	<input type="checkbox"/> Wheezing	<input type="checkbox"/> Blood in urine (Hematuria)	<input type="checkbox"/> Weakness
<input type="checkbox"/> Hearing loss	CARDIOVASCULAR	<input type="checkbox"/> Menstrual problem	HEMATOLOGIC
<input type="checkbox"/> Mouth sores	<input type="checkbox"/> Chest pain	<input type="checkbox"/> Pelvic pain	<input type="checkbox"/> Enlarged lymph node (Adenopathy)
<input type="checkbox"/> Nosebleeds	<input type="checkbox"/> Leg swelling	<input type="checkbox"/> Urgency	<input type="checkbox"/> Bruises/bleeds easily
<input type="checkbox"/> Postnasal drip	<input type="checkbox"/> Palpitations	<input type="checkbox"/> Urine decreased	PSYCHIATRIC
<input type="checkbox"/> Rhinorrhea (Runny Nose)	GASTROINTESTINAL	<input type="checkbox"/> Vaginal bleed	<input type="checkbox"/> Agitation
<input type="checkbox"/> Sinus pressure	<input type="checkbox"/> Abdominal distension	<input type="checkbox"/> Vaginal discharge	<input type="checkbox"/> Behavior problem
<input type="checkbox"/> Sneezing	<input type="checkbox"/> Abdominal pain	<input type="checkbox"/> Vaginal pain	<input type="checkbox"/> Confusion
<input type="checkbox"/> Sore throat	<input type="checkbox"/> Anal bleeding	MUSCULOSKELETAL	<input type="checkbox"/> Decreased concentration
<input type="checkbox"/> Tinnitus (Ringing in ear)	<input type="checkbox"/> Blood in stool	<input type="checkbox"/> Joint pain (Arthralgias)	<input type="checkbox"/> Dysphoric mood
<input type="checkbox"/> Trouble swallowing	<input type="checkbox"/> Constipation	<input type="checkbox"/> Back pain	<input type="checkbox"/> Hallucinations
<input type="checkbox"/> Voice change	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Gait problem	<input type="checkbox"/> Hyperactive
	<input type="checkbox"/> Nausea	<input type="checkbox"/> Joint swelling	<input type="checkbox"/> Nervous/anxious
	<input type="checkbox"/> Rectal pain	<input type="checkbox"/> Muscle pain (Myalgias)	<input type="checkbox"/> Self-injury
	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Neck pain	<input type="checkbox"/> Sleep disturbance
		<input type="checkbox"/> Neck stiffness	<input type="checkbox"/> Suicidal thoughts
		SKIN	
		<input type="checkbox"/> Color change	
		<input type="checkbox"/> Pale skin	
		<input type="checkbox"/> Rash	
		<input type="checkbox"/> Wound	