Iowa Kidney Physicians

NEW PATIENT HISTORY

Name: ______________________________ DOB: ________________

Review of Systems (Please check all **current** symptoms)

Cardiac
- ☐ Chest pain/heaviness
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Unable to breathe lying flat
- ☐ Palpitations

GI
- ☐ Diarrhea
- ☐ Constipation
- ☐ Abdominal pain
- ☐ Nausea
- ☐ Vomiting

GU
- ☐ Frequent urination
- ☐ Blood in urine
- ☐ Burning/pain with urination

HEENT
- ☐ Change in vision
- ☐ Decreased hearing
- ☐ Sinus problems

Hemo/Imm/Inf
- ☐ Fever or chills
- ☐ Swollen glands
- ☐ Bleeding problems
- ☐ Bruise easily

Musculoskeletal
- ☐ Joint pain/swelling
- ☐ Muscle pain/stiffness
- ☐ Increased weakness

Neuro/Psych
- ☐ Passing out
- ☐ Light headedness
- ☐ Numbness/tingling
- ☐ Headaches
- ☐ Confusion
- ☐ Depression
- ☐ Anxious/nervousness/irritability

Skin
- ☐ Rashes/itching
- ☐ Nonhealing sores/ulcers

Renal
- ☐ Difficulty concentrating
- ☐ Decreased urination
- ☐ Sleep disturbances
- ☐ Swelling arms/legs
- ☐ Bad taste in mouth
- ☐ Appetite decrease/increase
- ☐ Tired/fatigue
- ☐ Restless legs
- ☐ Sexual dysfunction
- ☐ Shortness of breath

Resp
- ☐ Cough
- ☐ Pain with breathing

☐ Other: (Please list)

____
____
____
____
____

Social History

Occupation: ______________________________

Level of Education: ☐ Elementary ☐ High School ☐ College ☐ Graduate School

Marital Status: ☐ M ☐ S ☐ D ☐ W Children: ______________________________

Coffee/Caffeine: Yes No Amount per day: ______________________________

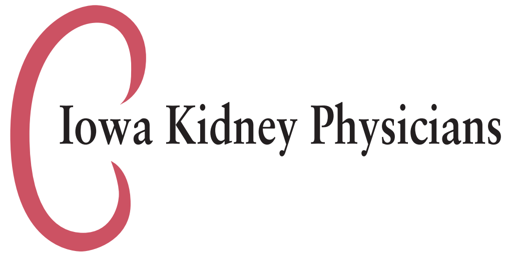
Smoking/Tobacco: Yes No Amount per day: ______________ # of years: ________ Stopped: ________

Alcohol use: Yes No Quantity: ______________ Frequency: ______________

Drug use: Yes No Substance: ______________ Frequency: ______________

Family History

	Living/Deceased	Age	Medical History	Cause of Death
Mother				
Father				
Sibling				
Sibling				
Sibling				
Sibling				
Sibling				
Sibling				



NEW PATIENT HISTORY

Name: ______________________________ DOB: ________________

Past Medical History: (Please check **ALL** that apply and approximate date of onset)

- ☐ Alcoholism
- ☐ Anemia
- ☐ Anxiety disorder
- ☐ Arthritis
- ☐ Asthma
- ☐ Bladder cancer
- ☐ Bleeding disorder
- ☐ Blood in urine
- ☐ Bronchitis/emphysema
- ☐ Cancer:
  - Type: ________________
  - Type: ________________
  - Type: ________________
- ☐ Circulation problems
- ☐ Clotting problems
- ☐ Congestive heart failure
- ☐ Coronary artery disease
- ☐ Depression
- ☐ Diabetes Mellitus
- ☐ Drug Abuse
- ☐ Edema/swelling
- ☐ Esophageal reflux
- ☐ Eye disease
- ☐ Gastrointestinal bleeding
- ☐ Gout
- ☐ Heart attack
- ☐ Hiatal hernia
- ☐ High blood pressure
- ☐ High cholesterol or lipids
- ☐ Kidney cancer
- ☐ Kidney disease
- ☐ Kidney stones
- ☐ Liver disease/hepatitis
- ☐ Lupus
- ☐ Migraine headaches
- ☐ Neuropathy
- ☐ Ovarian/uterine disease
- ☐ Parathyroid problems
- ☐ Pneumonia
- ☐ Protein in urine
- ☐ Problems urinating
- ☐ Prostate disease
- ☐ Renal artery stenosis/narrowing
- ☐ Respiratory infection
- ☐ Rheumatic fever
- ☐ Sleep apnea
- ☐ Skin rash or ulcers
- ☐ Thyroid problems
- ☐ TIA/stroke
- ☐ Testicular disease
- ☐ Tuberculosis
- ☐ Urinary tract infection
- ☐ Other: ________________
- ☐ Other: ________________
- ☐ Other: ________________
- ☐ Comments: ________________

____
____
____
____

Past Surgeries/Hospitalizations/Illnesses

Year	Hospital/Doctor	Reason

Any other information that you would like to share that you feel would be beneficial for us to know:

Concerns/questions I want to discuss with/ask my doctor today:

I have reviewed the above information.

Physician's Signature: ______________________________ Date: ________________

Iowa Kidney Physicians

NEW PATIENT HISTORY

PLEASE COMPLETE AND BRING WITH YOU TO YOUR APPOINTMENT

Appointment Date: ______________ Name: ____________________________ DOB: ______________ Sex: ☐ M ☐ F

Family Physician: ________________________________ Referring Physician: ________________________________

Reason for today's visit: ____

____

Other Physicians	Reason	Date Last Seen

Allergies/Reactions: ____

____

Please list your medications and include over the counter, herbal or alternative medicines.

Medications	Dose	How often	Ordering Doctor
(example) Lasix	*20mg*	*twice a day*	*Dr Helping*

Vaccinations/Immunizations If Yes, what year?

Hepatitis A Yes No ________________ Pneumonia vaccine Yes No ________________

Hepatitis B Yes No ________________ Tetanus Yes No ________________

Flu vaccine Yes No ________________ Other: ________________________