Patient History

Pediatric Nephrology

PLEASE COMPLETE FRONT AND BACK

Date	Date of Birth	Age	Sex Male Female
Last Name	First Name		Middle Initial
Street Address	City	State and zip code	Home Phone
Mother's or Guardian's Name	Occupation		Work Phone
Father's or Guardian's Name	Occupation		Work Phone
Other Ways to Reach You			
Pediatrician/Primary Care Doctor			Doctor's Phone
Other Doctors Involved in Your Child's Care			Doctor's Phone
Family Pharmacy			Pharmacy Phone

A. Why do you think your child needs to see a kidney doctor? _____

_____

B. Past Medical History

1. Birth History: Birth Weight: _____ Full Term / Premature (circle one)

   Pregnancy problems: _____

   Problems in Nursery / 1st month of life: _____

2. List any past medical problems your child has: _____

   _____

3. List any hospitalizations or surgeries your child has had. Please include the hospital and an approximate date: _____

   _____

4. List Allergies: _____

   _____

C. Family History

i. Any siblings? (sex and age please): _____

ii Has anyone in the patient's family had any of the following? If yes, check the box and list the person's relationship to the patient next to the problem.

- ❑ Kidney disease
- ❑ Kidney stones
- ❑ Kidney transplant
- ❑ Dialysis
- ❑ Urinary tract infections
- ❑ Bladder or kidney infections
- ❑ Blood in the urine
- ❑ Sickle cell trait or disease
- ❑ Bleeding or clotting problems
- ❑ Diabetes
- ❑ Thyroid problems
- ❑ Bowel disease
- ❑ Cancer
- ❑ An inherited disease
- ❑ High blood pressure
- ❑ High cholesterol
- ❑ Heart disease
- ❑ Stroke
- ❑ Obesity
- ❑ Other:

PLEASE COMPLETE FRONT AND BACK

D. Social History

1. Who lives in the same household with the patient?

Name	Age	Relationship to patient	Any health problems

2. Are the parent(s):

❑Single ❑Married ❑Divorced

❑Separated ❑Remarried

3. Patient's School history:

Grade: _____

Any problems in school: _____

_____

E. Review of Systems: Please check any of the following that are problems *for your child* and explain:

- ❑ Energy and activity level:
- ❑ Tea-colored urine:
- ❑ Bright red urine:
- ❑ Pain with urination:
- ❑ Frequent urination:
- ❑ Daytime wetting or leakage of urine:
- ❑ Wetting the bed:
- ❑ Foul smelling urine:
- ❑ Blood pressure problems:
- ❑ Constipation (hard or infrequent stools):
- ❑ Blood in stool:
- ❑ Nausea
- ❑ Vomiting:
- ❑ Diarrhea:
- ❑ Heartburn:
- ❑ Recurrent fevers:
- ❑ Swollen joints:
- ❑ Rashes:
- ❑ Weight loss:
- ❑ Unusual weight gain:
- ❑ Headaches:
- ❑ Visual problems:
- ❑ Hearing problems:
- ❑ Dental problems:
- ❑ Easy bruising:
- ❑ Heart murmur:
- ❑ Heart problems:
- ❑ Seizures:
- ❑ Wheezing or asthma
- ❑ Coughing:
- ❑ Sinus problems:
- ❑ Seizure: