Pharmacy Information

Pharmacy Name:

_____

Pharmacy Address:

_____

_____

Pharmacy Phone: Pharmacy Fax:

_____

Medication List

(or bring a comprehensive list to your appointment)

Name of Medication	Strength	Directions (i.e., 1 per day, 2 every 6 hours)

Have you ever taken any anti-inflammatory medications such as Advil, Motrin, Aleve, Celebrex, Vioxx, Ibuprofen, Naprosyn, Bextra, etc.? Yes____ No ____. If YES, please list medications:

_____
_____
_____
_____
_____

Medication allergies:

_____
_____
_____

Health History

Have you ever had the following? Please circle all that apply.

	NO	YES		NO	YES
Anemia	N	Y	High Cholesterol	N	Y
Arthritis	N	Y	Hyperlipidemia	N	Y
Asthma/COPD	N	Y	Hyperparathyroidism	N	Y
Atrial Fibrillation (AFIB)	N	Y	Hypertension	N	Y
Congestive Heart Failure (CHF)	N	Y	Kidney Cyst	N	Y
Cancer	N	Y	Kidney Failure	N	Y
Cancer within last 5 years	N	Y	Kidney Stones	N	Y
Coronary Artery Disease	N	Y	Lupus	N	Y
Diabetes Type 2	N	Y	Polycystic Kidney Disease	N	Y
Diabetes Type 1	N	Y	Proteinuria – Protein in Urine	N	Y
Heart Disease	N	Y	Recurrent Urinary Tract Infections	N	Y
Hematuria – Blood in Urine	N	Y	Stroke	N	Y
Hepatitis A	N	Y	Thyroid Disorders	N	Y
Hepatitis B	N	Y	Transplant	N	Y
Hepatitis C	N	Y	Vitamin D Deficiency	N	Y

Other

_____
_____

Previous Hospitalizations and Surgeries: (Please include dates)

_____
_____
_____
_____
_____

Family Medical History

Has anyone in your family had any of the following:

Kidney disease	Yes___ No___	If yes, list family member(s):_____
Protein in urine	Yes___ No___	If yes, list family member(s):_____
Blood in urine	Yes___ No___	If yes, list family member(s):_____
Dialysis	Yes___ No___	If yes, list family member(s):_____
Diabetes Type 1	Yes___ No___	If yes, list family member(s):_____
Diabetes Type 2	Yes___ No___	If yes, list family member(s):_____
Hypertension	Yes___ No___	If yes, list family member(s):_____
SLE	Yes___ No___	If yes, list family member(s):_____
Kidney Stones	Yes___ No___	If yes, list family member(s):_____
Polycystic Kidney Disease	Yes___ No___	If yes, list family member(s):_____
Cancer	Yes___ No___	If yes, list family member(s):_____
Deafness	Yes___ No___	If yes, list family member(s):_____
Other?	Yes___ No___	

If yes, please specify illness and family member(s):

_____

Current Social History (circle)

Alcohol intake: None Occasionally Moderate Heavy _____

Chewing Tobacco: None 1 per day 2-4 per day 5+ per day_____

Tobacco - years of use: _____

Smoking Status: Never Former Smoker | Current every day Smoker | Current some day Smoker | Smoker – current Status unknown | Unknown if ever Smoked

Smoking – How much?: None | 1 PPW | 2 PPW | 1/4 PPD | 1/2 PPD | 1 PPD | 1 1/2 PPD | 2 PPD | 3+ PPD

Has smoked since age: _____

Illicit drugs: _____

Marital Status: Unknown Married Single Divorced Separated Widowed Domestic Partner

Occupation: _____

REVIEW OF SYSTEMS

Please circle and describe how you are feeling today

Constitutional: Fever Fatigue Weight gain (_____ lbs) Weight loss (_____ lbs)

Eyes: Dry eyes Vision change

Nose: Frequent nosebleeds

Mouth/Throat: Sore throat Snoring Dry mouth

Cardiovascular: Chest pain on exertion Shortness of breath when walking Palpitations
Known heart murmur Light-headed on standing Swelling in the extremities

Respiratory: Cough Wheezing Shortness of breath Coughing up blood Sleep apnea

Gastrointestinal: Abdominal pain Vomiting Change in appetite Frequent diarrhea Nausea

Genitourinary: Urinary loss of control Difficulty urinating Increased urinary frequency
Blood in urine

Musculoskeletal: Muscle aches Arthralgias/joint pain Back pain

Skin: Jaundice Rash Itching

Psychiatric Depression Restless sleep

Endocrine: Increased thirst Heat intolerance Cold intolerance

Hematologic/Lymphatic: Swollen glands Easy bruising Excessive bleeding

Allergy/Immunologic: Runny nose Itching Hives