Michigan Kidney Consultants, P.C. Today's Date

Past personal, Family, Social history and review of systems

To be completed by patient Please print

Name Date of Birth

Past Medical History

What brings you to see the Doctor today?

Who sent you to our office?

What medications are you allergic to?

What medications are you currently taking? *Please include the name, strength, and how many times/day you take them*

1) 6)

2) 7)

3) 8)

4) *9)*

5) *10)*

What surgeries or biopsies have you had? *Type, Year, Which Hospital*

Have you ever been diagnosed with any of the following medical conditions? *Please check all that apply*

DIABETES TYPE 1 or 2	☐	KIDNEY STONES	☐	EMPHYSEMA	☐
HIGH BLOOD PRESSURE	☐	KIDNEY INFECTION	☐	ASTHMA	☐
CONGESTIVE HEART FAILURE	☐	PANCREATITIS	☐	BRONCHITIS	☐
HEART ATTACK	☐	HEPATITIS	☐	STROKE	☐
STOMACH ULCERS	☐	ARTHRITIS	☐	EPILEPSY/SEIZURES	☐
GALLBLADDER PROBLEMS	☐	ANEMIA	☐	CANCER Type	☐
COLON PROBLEMS	☐	TUBERCULOSIS	☐	I HAVE ***NOT*** HAD ANY OF THE PREVIOUS ILLNESSES	☐

Please list any other illnesses

Pregnancies: Yes ◯ No ◯ How many total? How many were live births?

Family History Please list any BLOOD relatives that have had any of the following conditions ***(Mother, Father, Sibling, Child)***

High Blood Pressure	Kidney Disease
Diabetes	Stroke
Cancer	Gout
Heart Disease	Dementia

Is your FATHER: Living ◯ Deceased ◯ Unknown ◯ Is your MOTHER: Living ◯ Deceased ◯ Unknown ◯

Father's Age at Death (If applicable) Mother's Age at Death (If applicable)

Father's Cause of Death Mother's Cause of Death

Review of Systems

Please check YES or No for items which have occurred recently or have been significant in the past

Constitutional			**Urinary**		
Fever	Yes	No	Urgency	Yes	No
Weight Gain	Yes	No	Burning or Pain	Yes	No
Weight Loss	Yes	No	Blood in urine	Yes	No
Fatigue	Yes	No	Frequency	Yes	No
Weakness	Yes	No	Hesitancy	Yes	No
HEENT			Foamy urine	Yes	No
Vision Impairment	Yes	No	Incontinence	Yes	No
Eye pain	Yes	No	Night time urination	Yes	No
Redness	Yes	No	**Musculoskeletal**		
Color blindness	Yes	No	Back pain	Yes	No
Double vision	Yes	No	Neck pain	Yes	No
Hearing loss	Yes	No	Joint pain	Yes	No
Ear pain	Yes	No	Muscle pain	Yes	No
Sinus problems	Yes	No	Arm weakness	Yes	No
Sore throat	Yes	No	leg weakness	Yes	No
Nose Bleeds	Yes	No	**Skin**		
Headache	Yes	No	Rash	Yes	No
Hoarseness	Yes	No	Itching	Yes	No
Tinnitus	Yes	No	Scaling	Yes	No
Vertigo	Yes	No	Dryness	Yes	No
Respiratory			Color change	Yes	No
Shortness of breath	Yes	No	**Neurological**		
Pain with breathing	Yes	No	Numbness	Yes	No
Cough	Yes	No	Tremors	Yes	No
Wheezing	Yes	No	Seizures	Yes	No
Night sweats	Yes	No	Tingling	Yes	No
Cardiovascular			Fainting	Yes	No
Chest pain	Yes	No	**Endocrine**		
Palpitations	Yes	No	Too hot	Yes	No
Swelling	Yes	No	Too cold	Yes	No
Irregular pulse	Yes	No	Excessive thirst	Yes	No
Gastrointestinal			Excessive urination	Yes	No
Abdominal pain	Yes	No	**Psychiatric**		
Nausea	Yes	No	Depression	Yes	No
Diarrhea	Yes	No	Insomnia	Yes	No
Heartburn	Yes	No	Anxiety	Yes	No
Vomiting	Yes	No	**Hematology**		
Constipation	Yes	No	Bleeding gums	Yes	No
Loss of appetite	Yes	No	Easily bruising	Yes	No

Patient Signature _____ PhysicianSignature _____

Michigan Kidney complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.
ATTENTION: language assistance services, free of charge, are available to you. If you need these services, contact Gayle Robichaud 248-290-3111 ext 1713