TEXAS KIDNEY CENTER
caring for your kidneys in a conscientious way

Confidential Patient History Questionnaire

The information provided will be strictly confidential and will be used for the purpose of medical care only.

Name:	Age:	Today's Date:
Gender Identity: ❑ Female ❑ Male ❑ Non-Binary ❑ Prefer not to say ❑ Self-Identification: _____		
Pronouns: ❑ She/Her ❑ He/Him ❑ They/Them/Theirs ❑ Prefer not to say ❑ Self- Identification: _____		
What are the concerns for which you are seeking care?		

Personal History

Place of Birth:	
Highest level of education: ❑ High school ❑ Some college ❑ College graduate ❑ Advanced degree	
Work status: ❑ Employed ❑ Unemployed ❑ Retired ❑ Disabled	Current or prior occupation:
Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed ❑ Partnered ❑ Other	# of children:

On the scale of 1-10 (1- lowest, 10- highest), mark your stress level below:

1	2	3	4	5	6	7	8	9	10

Social History

Tobacco	Do you use tobacco products? ❑ Yes ❑ No	Form: ❑ Cigarette ❑ Cigar ❑Pipe ❑ Chew	# of packs per day:
	Are you a former smoker? ❑ Yes ❑ No	What year did you quit?	# of years smoked:
Alcohol	Do you drink alcohol? ❑ Yes ❑ No	Type of alcohol:	# of drinks per week:
Drugs	Do you use recreational drugs? ❑ Yes ❑ No	Type: ❑ Cannabis ❑ Cocaine ❑ Heroin ❑ Other:	

Habits

Caffeine	Do you drink coffee? ❑ Yes ❑ No	# of cups of coffee per day/week:
	Do you drink black or green tea? ❑ Yes ❑ No	# of cups of tea per day/week:
Drinks	Describe your water intake throughout the day:	
	Do you drink energy drinks? ❑ Yes ❑ No	# of energy drinks per day/week:
	Do you drink cola or other sodas? ❑ Yes ❑ No	# of sodas per day/week:
	Do you add flavors to your water (e.g. crystal light): ❑ Yes ❑ No	What kind?
	Do you consume any other drinks (e.g. milk, juice): ❑ Yes ❑ No	What drinks?
Activities	What are your hobbies?	
	How many hours do you sleep?	Do you spend time outdoors? ❑ Yes ❑ No
	Do you watch TV? ❑ Yes ❑ No, Hours/day?	Do you read? ❑ No ❑ Yes, how often?
	Do you exercise daily? ❑ Yes ❑ No	Type: / How often?
	Do you enjoy your work? ❑ Yes ❑ No	Do you take vacations? ❑ Yes ❑ No
Lifestyle	Are you in a supportive relationship? ❑ Yes ❑ No	Any history of major trauma? ❑ Yes ❑ No
	Have you been physically, sexually, or emotionally abused? ❑ Yes ❑ No	
	Do you travel within or outside of U.S.? ❑ Yes ❑ No	Last day of travel:

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Lifestyle	Do you have any tattoos? ❑ Yes ❑ No	Year of tattoo:
	Have you had any chemical exposure? ❑ Yes ❑ No	
	Do you have a TV in your bedroom? ❑ Yes ❑ No	

Sexual History

Are you sexually active? ❑ Yes ❑ No	Sexual preference: ❑ Men ❑ Women ❑ Both
Have you ever had a sexually transmitted disease? ❑ Yes ❑ No, if yes, please specify:	

OB/GYN History

Have you ever been pregnant? ❑ Yes ❑ No	# of pregnancies:	# of miscarriages:	# of abortions:
Do you use contraception? ❑ Yes ❑ No, What kind?		Are you breastfeeding or pregnant? ❑ Yes ❑ No	
If pregnant, what is the expected delivery date?		How many weeks pregnant are you?	
Complications during pregnancy: ❑ Gestational Diabetes ❑ Preeclampsia ❑ Others, please specify:			
Age at first menses:	Menstrual periods: ❑ Regular ❑ Irregular ❑ Menopausal	Age at menopause:	

Transplant History

Do you have a history of organ transplantation? ❑ Yes ❑ No, if yes, please specify from the options below:		
❑ Kidney transplant	❑ Liver transplant	❑ Others, please specify:
Date of transplantation:		

Family History

Indicate if there have been any of the following diseases in your parents, grandparents, brothers, sisters, or children.

	Mother	Maternal GM	Maternal GF	Father	Paternal GM	Paternal GF	# of siblings	# of children	Extended family
Kidney Disease									
Polycystic Kidney Disease									
Dialysis									
Sickle cell nephropathy									
Transplantation									
Heart disease									
Stroke									
Diabetes									
Hypertension									
Cancer									
Others:									

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Past Medical History					
	Onset date		Onset date		Onset date
Kidney Disease ❑ Polycystic Kidney ❑ Nonsteroidal anti-inflammatory drug (NSAID) use ❑ History of frequent Urinary Tract Infection (UTI) ❑ Kidney stones ❑ Glomerular disease **Heart Disease** ❑ Coronary Artery Disease ❑ Congestive Heart Failure ❑ History of heart attack ❑ Valve Disorder ❑ Hypertension **Infectious Disease** ❑ HIV ❑ Hepatitis B/C ❑ Syphilis **Skin Disorders** ❑ Eczema ❑ Melanoma ❑ Psoriasis		**Neurological disorders** ❑ Migraine ❑ Stroke ❑ Epilepsy ❑ Peripheral Neuropathy **Pulmonary Disease** ❑ Asthma ❑ Emphysema ❑ Chronic Cough ❑ Tuberculosis **Connective Tissue Disease** ❑ Rheumatoid Arthritis ❑ Osteo Arthritis ❑ Lupus ❑ Scleroderma **Cancer** ❑ Breast cancer ❑ Lung cancer ❑ Kidney cancer ❑ Other (Please specify)		**Endocrine Disorder** ❑ Type 1 Diabetes ❑ Type 2 Diabetes ❑ Hyperglycemia ❑ Hypothyroidism **Gastrointestinal Disease** ❑ GERD / Acid Reflux ❑ Irritable Bowel Syndrome ❑ Stomach ulcer **Blood Disorders** ❑ History of blood clots ❑ Anemia ❑ Sickle Cell Disease **Psychiatric Disorders** ❑ PTSD ❑ Anxiety ❑ Depression **Others (**please specify**)**	

Past Surgical History					
Surgery	Year Performed	Surgery	Year Performed	Surgery	Year Performed
❑ **None** **Cardiovascular** ❑ Heart valve surgery ❑ Coronary Artery Bypass ❑ Cardiac Stents ❑ Pacemaker **Gastrointestinal** ❑ Appendectomy ❑ Colectomy ❑ Cholecystectomy **Transplant Surgery** ❑ Kidney transplant ❑ Heart transplant ❑ Lung transplant ❑ Other:		**Renal** ❑ Nephrectomy ❑ Cystectomy ❑ Lithotripsy **Lymphatic** ❑ Tonsillectomy ❑ Splenectomy **Orthopedic Surgery** ❑ Knee Replacement ❑ Right ❑ Left ❑ Shoulder Replacement ❑ Right ❑ Left ❑ HIP Replacement ❑ Right ❑ Left ❑ Other:		**OB/GYN** ❑ Cesarean Section ❑ Tubal Ligation ❑ Cervical biopsy ❑ Hysterectomy ❑ Oophorectomy **Eye** ❑ Cataract Surgery ❑ Laser ❑ Photocoagulation ❑ Glaucoma surgery **Other (Please list** below)	
Please list any complications with surgery:					

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Review of Symptoms		
System	**Symptoms/ Problem**	**Others**
General	❑ chills ❑ changes in weight ❑ sleep pattern change ❑ appetite change	
Eyes/ Vision	❑ Blurred ❑ pain in eyes ❑ Dry eyes	
Ears, Nose, Throat	❑ ear pain ❑ Decreased smell ❑ Sinusitis ❑ Hoarseness	
Mouth	❑ Dry mouth ❑ Sores ❑ Ulcers ❑ Blisters ❑ Loss of taste	
Heart	❑ Chest pain ❑ feeling heart beats ❑ Palpitations ❑ Irregular Rhythm	
Lung	❑ Short of breath ❑ Cough ❑ Wheezing ❑ Sputum	
Circulation	❑ Pain with walking ❑ ankle swelling ❑ Claudication ❑ Varicosities	
Digestive Tract	❑ Nausea ❑ Constipation ❑ Heartburn ❑ Abdominal Pain ❑ Diarrhea	
Kidney/ Urinary	❑ painful urination ❑ Bleeding ❑ Incontinence ❑ Frequent urination at night ❑ Loss of Urine during coughing, sneezing, or laughing ❑ edema	
Skin/ Breast	❑ Rash ❑ Lump ❑ Itching ❑ Hair/ Nails change	
Gynecology	❑ Heavy menstrual bleeds ❑ severe cramping ❑ pain with sex	
Endocrine	❑ Excess thirst ❑ Decreased energy ❑ Fatigue ❑ bowel habit changes	
Neurologic	❑ Headache ❑ Numbness/ Tingling ❑ Seizure ❑ Vertigo ❑ Dizziness	
Psychiatric	❑ Depression ❑ Anxiety ❑ Sleep disorder ❑ Hallucinations	
Hematology	❑ Bleeding problems ❑ Easy Bruising	
Musculoskeletal	❑ Muscle pain ❑ Joint pain ❑ Motion Loss ❑ back pain	

Current Medications

Check ALL **that you currently use:**

❑ Pain relievers, **Type:** ❑ Ibuprofen ❑ Advil ❑ Aleve ❑ Naproxen ❑ Tylenol ❑ Other:

❑ Antibiotics	❑ Antidepressants	❑ Antacids

Please list all the medications including over-the-counter medications in the space below:

Medication Name and Dosage	**Frequency**	**Prescriber's Name**	**Medication Name and Dosage**	**Frequency**	**Prescriber's Name**
1.			**10.**		
2.			**11.**		
3.			**12.**		
4.			**13.**		
5.			**14.**		
6.			**15.**		
7.			**16.**		
8.			**17.**		
9.			**18.**		