TEXAS KIDNEY SPECIALISTS, P.A.

Review of Systems

Please complete this form to the best of your ability prior to your new patient appointment.

Patient Name		Date of Birth	
Referring Doctor		Primary Care Doctor	
Email Address, if you want access to patient portal:			

RELEVANT CURRENT HISTORY	YES	NO	COMMENTS
1. High Blood Pressure	☐	☐	
2. Diabetes	☐	☐	
a. Eye Damage? (laser treatment)	☐	☐	
b. Nerve Damage? (numbness, decreased feeling in feet)	☐	☐	
c. Kidney Damage?	☐	☐	

RENAL HISTORY	YES	NO	COMMENTS
1. History of blood in urine?	☐	☐	
2. History of protein in urine?	☐	☐	
3. Use any pain medicine? a. List type and amount.	☐	☐	
4. Did you check blood pressure at home?	☐	☐	
5. History of urinary tract infection, bladder infection or kidney infection?	☐	☐	
6. History of kidney stones?	☐	☐	
7. Any burning, pain or discomfort urinating?	☐	☐	
8. Trouble with leg swelling?	☐	☐	
9. Any kidney or bladder surgery?	☐	☐	

REVIEW OF SYSTEMS	YES	NO	COMMENTS
CONSTITUTIONAL			
• Weight Gain?	☐	☐	

• Fevers?	☐	☐	
REVIEW OF SYSTEMS	**YES**	**NO**	**COMMENTS**
• Chills?	☐	☐	
• Sweats?	☐	☐	
• Fatigue?	☐	☐	
EYES			
• Changes in vision?	☐	☐	
• Loss of vision?	☐	☐	
• Blurred vision?	☐	☐	
EARS			
• Difficulty Hearing?	☐	☐	
• Hearing Loss?	☐	☐	
• Ear Pain?	☐	☐	
NOSE			
• Nasal Congestion?	☐	☐	
• Nasal Discharge?	☐	☐	
• Nosebleeds?	☐	☐	
MOUTH			
• Lip Sores?	☐	☐	
• Mouth Sores?	☐	☐	
• Sore Throat?	☐	☐	
• Difficulty Swallowing?	☐	☐	
RESPIRATORY			
• Cough?	☐	☐	
• Shortness of breath with exertion?	☐	☐	
• Whistling sound when breathing?	☐	☐	
• Coughing Blood?	☐	☐	
CARDIOVASCULAR			
• Chest pain with exertion?	☐	☐	
• Palpitations?	☐	☐	
• Shortness of breath or difficulty breathing when lying down?	☐	☐	
• Shortness of breath at rest?	☐	☐	
• Swelling of legs?	☐	☐	
GASTROINTESTINAL			
• Abdominal Pain?	☐	☐	
• Nausea?	☐	☐	
• Vomiting?	☐	☐	
• Diarrhea?	☐	☐	
URINARY			
• Burning sensation while peeing?	☐	☐	
• Blood in urine?	☐	☐	
• Increased urinary frequency?	☐	☐	
• Decreased urinary frequency?	☐	☐	

REVIEW OF SYSTEMS	YES	NO	COMMENTS	
MUSCULOSKELETAL				
• Muscle pain?	☐	☐		
• Joint pain?	☐	☐		
• Back pain?	☐	☐		
• Muscle cramps?	☐	☐		
SKIN				
• Rash?	☐	☐		
• Bruising?	☐	☐		
• Hives?	☐	☐		
• Dry skin?	☐	☐		
NEUROLOGIC				
• Headaches?	☐	☐		
• Vertigo?	☐	☐		
• Light-headedness?	☐	☐		
• Dizziness?	☐	☐		
ENDOCRINE				
• High or low blood sugar?	☐	☐		
• Excessive or extreme hunger?	☐	☐		
• Excessive thirst?	☐	☐		
• Excess formation of urine?	☐	☐		
MENTAL HEALTH				
• Depression?	☐	☐		
• Anxiety?	☐	☐		
• Changes in mood?	☐	☐		
• Sleep disturbances?	☐	☐		
BLOOD OR CANCER PROBLEMS				
• History of anemia or low blood counts?	☐	☐		
• Do you take blood thinner?	☐	☐		
• Do you have a history of cancer?	☐	☐		
FAMILY MEDICAL HISTORY			**Are They Alive?**	
• Anyone with kidney stones?	☐	☐	Y / N	
• Anyone with kidney disease, such as protein or blood in urine or kidney failure?	☐	☐	Y / N	
• Anyone with high blood pressure?	☐	☐	Y / N	
• Anyone with heart or blood vessel disease?	☐	☐	Y / N	
SOCIAL HISTORY				
• Do you work?	☐	☐		
• Do you use tobacco?	☐	☐		
• Do you consume alcohol?	☐	☐		
• Do you use drugs?	☐	☐		

ALLERGIES? (Please list below)

MEDICATIONS? (Please list below and bring in to your appointment. Make sure to include over the counter medications, mineral and herbal supplements)

PAST MEDICAL HISTORY? (Please list problems and any recent hospitalizations)

PAST SURGICAL HISTORY? (Please list any surgeries and dates)

Patient Name	
Patient Signature	
Today’s Date	