The Everett Clinic
For the whole you.
3901 Hoyt Avenue ■ Everett, WA 98201 ■ 425-259-0966

Nephrology – Intake Form

Name _____ Today's Date _____

Birthdate _____ Age _____

Please check any of the following problems that currently apply to you:

General Health: ☐ **No Problems** (Or check all that apply below)
- ☐ Fevers, chills, or night sweats
- ☐ Fatigue
- ☐ Weakness
- ☐ Unintentional Weight Loss
- ☐ Sleep Problems
- ☐ Other: _____

Mental Health ☐ **No Problems** (Or check all that apply below)
- ☐ Memory problems
- ☐ Anxiety or nervousness
- ☐ Depression
- ☐ Delusions or hallucinations
- ☐ Other: _____

Neurology ☐ **No Problems** (Or check all that apply below)
- ☐ Difficulty concentrating
- ☐ One or more falls in the past 6 months
- ☐ Numbness or tingling
- ☐ Fainting
- ☐ Poor balance
- ☐ Weakness
- ☐ Tremors
- ☐ Other: _____

Eyes ☐ **No Problems** (Or check all that apply below)
- ☐ Blurry vision
- ☐ Double vision
- ☐ Damage from diabetes or high blood pressure
- ☐ Cloudy vision
- ☐ Loss of vision
- ☐ Other: _____

Ears, Nose, and Throat ☐ **No Problems** (Or check all that apply below)
- ☐ Hearing problems
- ☐ Sinus drainage or congestion
- ☐ Dental problems
- ☐ Ringing in ears
- ☐ Dry mouth
- ☐ Sore throat
- ☐ Other: _____

Respiratory ☐ **No Problems** (Or check all that apply below)

☐ Cough
☐ Shortness of breath with activity
☐ Frequent respiratory infections
☐ Trouble breathing while lying down
☐ Shortness of breath
☐ Wheezing
☐ Coughing up blood
☐ Other: _____

Cardiovascular ☐ **No Problems** (Or check all that apply below)

☐ Chest pain or pressure
☐ Previous cardiac testing
☐ Leg pain with walking
☐ Chest pain with exertion
☐ Irregular heart beat
☐ Other: _____

Gastrointestinal ☐ **No Problems** (Or check all that apply below)

☐ Difficulty swallowing
☐ Nausea or vomiting
☐ Bloating / Gas
☐ Diarrhea
☐ Blood in stool
☐ Change in appetite or taste
☐ Heartburn
☐ Jaundice or liver disease
☐ Constipation
☐ Other: _____

Genitourinary ☐ **No Problems** (Or check all that apply below)

☐ Difficulty urinating
☐ Weak urinary system
☐ Frequent urination
☐ Protein in urine
☐ Incontinence
☐ Painful or heavy periods
☐ Pain with intercourse
☐ Impotence
☐ Painful urination
☐ Blood in urine
☐ Frequent urination at night
☐ Flank pain
☐ Irregular periods
☐ Vaginal discharge
☐ Other: _____

Skin ☐ **No Problems** (Or check all that apply below)

☐ Rash
☐ Skin cancer
☐ Other: _____

Endocrine ☐ **No Problems** (Or check all that apply below)

☐ High blood sugars
☐ Increased thirst
☐ Thyroid problems
☐ Other: _____

Hematology ☐ **No Problems** (Or check all that apply below)

☐ Easy bruising or bleeding
☐ Blood clots
☐ Other: _____

Please check any of the following problems that you have experienced in the past:

- ☐ Diabetes
- ☐ Diabetes retinopathy
- ☐ Diabetes neuropathy
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Heart attack / angina
- ☐ Stroke
- ☐ Family history of renal disease
- ☐ Family history of polycystic disease
- ☐ Blood in urine
- ☐ Protein in urine
- ☐ Autoimmune disease
- ☐ Cancer
- ☐ Blood clots / phlebitis
- ☐ Hepatitis
- ☐ HIV / AIDS
- ☐ Frequent urinary infections
- ☐ Chronic infections
- ☐ Kidney stones
- ☐ Urinary obstruction
- ☐ Vesico – ureteral reflux
- ☐ Congestive heart failure
- ☐ Sleep apnea
- ☐ Lithium exposure
- ☐ Chronic NSAID use
- ☐ Contrast dye nephropathy
- ☐ Kidney transplant rejection
- ☐ Gout

Please check any of the following surgical procedures you have had in the past:

- ☐ Nephrectomy
- ☐ Prostatectomy
- ☐ Kidney transplant
- ☐ Hysterectomy
- ☐ Peripheral vascular bypass
- ☐ VSD repair
- ☐ Lithotripsy
- ☐ Bladder surgery
- ☐ Kidney removal
- ☐ Cardiac stent
- ☐ Coronary bypass

Do you currently consume 1 or more alcoholic beverages per week? _____

Do you currently use tobacco products? _____

If yes, how often? _____

- ☐ Cigarettes
- ☐ Cigars
- ☐ Pipe
- ☐ Snuff
- ☐ Chew

Do you currently use any illicit (non-prescription narcotic) drugs? _____