BERGEN KIDNEY CENTER

REVIEW OF SYSTEMS

Samuel A. Agahiu, MD
Louis C. Jan, MD
Marc S. Zelkowitz, MD

Name/DOB: _____/_____ Date: _____

Reason for Referral: _____

Referred By: _____ MD Patient Facility

Please list other doctors or specialists involved in your medical care: _____

_____

Past Medical History (Please list problems and any recent hospitalizations): _____

_____

_____

Past Surgical History (Please list surgeries and dates): _____

_____

_____

Allergies: _____

Medications (Please list all current medications below. Be sure to include herbal supplements and over the counter meds):

Medication Name

Renal History:	**Circle One:**		**Comments:**
Kidney x-rays, ultrasound, IVP, CT Scan?	Yes	No	_____
24 Hour Urine Collection?	Yes	No	_____
History of blood in urine?	Yes	No	_____
History of protein in urine?	Yes	No	_____
Do you use prescription pain medicine?	Yes	No	_____
History of UTI, Bladder or Kidney infection?	Yes	No	_____
History of kidney stones?	Yes	No	_____
Do you get up at night to urinate?	Yes	No	_____
Do you have difficulty holding your urine (incontinence)?	Yes	No	_____
Do you have pain, burning or discomfort while urinating?	Yes	No	_____
Do you have flank pain?	Yes	No	_____
Do you have leg swelling?	Yes	No	_____
Have you ever had kidney or bladder surgery?	Yes	No	_____

Relevant Current History:

High Blood Pressure:	Yes	No	_____
For how many years? _____			
Do you check your blood pressure at home?	Yes	No	_____
What are your average readings? _____			
Diabetes:	Yes	No	_____
For how many years? _____			
Do you check your blood sugar at home?	Yes	No	_____
Eye damage/Laser Treatment?	Yes	No	_____
Nerve damage (numbness/decreased feeling in feet)	Yes	No	_____
Kidney damage or protein in urine?	Yes	No	_____

Constitutional:

Any weight loss or gain?	Yes	No	_____
Fevers, chills or sweats?	Yes	No	_____
Fatigue or weakness?	Yes	No	_____

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Name: _____ DOB:_____

HEENT:

Any blurry vision or vision problems?	Yes	No	_____
Have you had your eyes examined?	Yes	No	_____
If so, when? _____			
Any hearing problems?	Yes	No	_____

Cardiac:

Chest Pain?	Yes	No	_____
Previous Heart Surgery?	Yes	No	_____
Cardiac Catheterization?	Yes	No	_____
Stress Test?	Yes	No	_____
Echocardiogram?	Yes	No	_____

Pulmonary:

Cough?	Yes	No	_____
History of asthma or emphysema?	Yes	No	_____
Shortness of breath with exertion?	Yes	No	_____
History of tuberculosis? (TB)	Yes	No	_____

Gastrointestinal:

History of gastrointestinal bleeding?	Yes	No	_____
History of recurrent nausea/vomiting?	Yes	No	_____
Prior endoscopy/colonoscopy?	Yes	No	_____
Heartburn/Indigestion?	Yes	No	_____
Ulcer Disease?	Yes	No	_____
History of liver disease or yellowing skin?	Yes	No	_____
Diarrhea or constipation?	Yes	No	_____

Musculoskeletal:

Gout?	Yes	No	_____
Muscle or joint aches?	Yes	No	_____
Do you use pain pills frequently?	Yes	No	_____

Vascular:

Prior arteriogram or dye x-ray of abdomen, Legs, neck or brain?	Yes	No	_____
Angioplasty (Balloon opening of blood vessel) or stent?	Yes	No	_____
Surgical Bypass?	Yes	No	_____
Aneurysm of Aorta?	Yes	No	_____
Cramping or pain in legs with walking?	Yes	No	_____

Skin/Rheumatologic:

Rash?	Yes	No	_____
Arthritis?	Yes	No	_____

Neurologic:

TIA or Mini-stroke?	Yes	No	_____
Stroke? If yes, what body parts were affected?	Yes	No	_____
History of seizures?	Yes	No	_____
History of nerve damage?	Yes	No	_____
Carotid Ultrasound?	Yes	No	_____

Endocrine:

History of high/low blood sugar?	Yes	No	_____
Thyroid issues?	Yes	No	_____
Cholesterol problems?	Yes	No	_____
Osteoporosis	Yes	No	_____
Vertebral fractures or other fractures?	Yes	No	_____

Blood or Cancer:

History of Anemia or low blood counts?	Yes	No	_____
History of easy bruising or bleeding?	Yes	No	_____
Have you ever had a blood transfusion?	Yes	No	_____
Do you have history of any cancer?	Yes	No	_____

Psychiatry:

Depression	Yes	No	_____
Anxiety?	Yes	No	_____

Social History:

Do you use tobacco?	Yes	No	_____
Do you use alcohol?	Yes	No	_____
Do you use recreational drugs?	Yes	No	_____
Do you work? If yes, What kind?	Yes	No	_____

Family History:

Anyone with kidney disease? Protein or blood in urine or kidney failure?	Yes	No	_____
Anyone with kidney stones?	Yes	No	_____

Relatives (Current age or age at death)	Living	Deceased	Cause of Death/Disease
Father: _____	_____	_____	_____
Mother: _____	_____	_____	_____

Please list any siblings with age: