32000-04

Children's Physician Group - Nephrology
Children's Specialty Services

NEW PATIENT QUESTIONNAIRE

Name_____

Date of Birth_____

MRN#_____

Account/HAR#_____

PATIENT IDENTIFICATION

Name: _____ DOB: _____ Date: _____

Welcome to the Pediatric Nephrology Service. Please complete this patient questionnaire before your appointment and bring it with you in order that we may serve you better. Please print clearly. Thank you.

Reason for Clinic Visit

Why was your child referred to the Pediatric Nephrologist (kidney specialist) and when was this problem first noticed?

_____

_____

_____

Social History

Does your child attend school? Yes _____ No _____ If yes, what grade?

_____

Past Medical History

1. List any surgical procedures your child has undergone.

_____ _____ _____

_____ _____ _____

2. List the reasons for any previous hospitalization.

_____ _____ _____

_____ _____ _____

Medication Allergies

List names of medications and types of reactions (e.g. skin rash, stomach upset). ☐ No Allergies

_____ _____

_____ _____

Family History

Father: Age _____ Height: _____ Is there any history of kidney or bladder disease, kidney stones or high blood pressure?
Yes ____ No ____ Which? _____

Mother: Age ____ Height: _____ Is there any history of kidney or bladder disease, kidney stones or high blood pressure?
Yes ____ No ____ Which? _____

Brothers or sisters. List names, ages, and any related health problems.

_____ _____

_____ _____

Has any family member ever had hearing loss at a young age? _____

Does any other relative have kidney or bladder problems, kidney stones, or high blood pressure? Yes ___ No ___

List relationship of any relatives with any of these problems _____

_____ _____

_____ _____

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Review of Systems

Please check yes or no for the following questions.

	Yes	No
General		
Recent weight changes	☐	☐
Growth problems	☐	☐
Fatigue	☐	☐
Change in appetite	☐	☐
Increased sleeping	☐	☐
Increased thirst	☐	☐
Skin		
Rash	☐	☐
Lumps or bumps	☐	☐
Stretch marks	☐	☐
Nervous System		
Headaches	☐	☐
Dizziness	☐	☐
Fainting	☐	☐
Changes in behavior	☐	☐
Seizures	☐	☐
Eyes		
Vision problems	☐	☐
Swelling around the eyes	☐	☐
Ears		
Ringing in the ears	☐	☐
Loss of hearing	☐	☐
Nose		
Nosebleeds	☐	☐
Mouth		
Gum problems	☐	☐
Sores in mouth	☐	☐

	Yes	No
Throat		
Recent sore throat	☐	☐
Difficulty swallowing	☐	☐
Heart and Lungs		
Chest pain	☐	☐
Heart murmur	☐	☐
Difficulty breathing	☐	☐
Cough	☐	☐
Stomach and Intestines		
Stomach pain	☐	☐
Bloody or back stools	☐	☐
Constipation	☐	☐
Diarrhea	☐	☐
Kidney/Urine/Bladder		
Pain or burning on urination	☐	☐
Blood in urine	☐	☐
Frequent urination	☐	☐
Bedwetting	☐	☐
Getting up at night to urinate	☐	☐
Blood		
Anemia	☐	☐
Easy Bruising	☐	☐
Muscles/Joints/Extremities		
Muscle weakness	☐	☐
Joint pain	☐	☐
Joint swelling	☐	☐
Immunizations		
Are shots up to date?	☐	☐
Menstrual (females only)		
Menses started	☐	☐
Irregular periods	☐	☐
Recent missed periods	☐	☐

Parent/Patient/Legal Guardian Signature: _____ Date:_____ Time:_____

Reviewed by: Provider/Physician Signature: _____ Date: _____ Time: _____

Reviewed by: Resident/Fellow Signature: _____ Date: _____ Time: _____