The Centers for Kidney Care

ENCOUNTER FORM

REVIEW OF SYSTEMS Check only those that apply **Patient Name** _____

Constitutional	____ Fever	____ Fatigue
	____ Weight Gain	____ Chills
	____ Weight Loss	____ Weakness
HEENT	____ Vision Impaired	____ Sinus Problems
	____ Eye Pain	____ Sore Throat
	____ Redness	____ Nose Bleeds
	____ Color Blindness	____ Headache
	____ Double Vision	____ Hoarseness
	____ Hearing Loss	____ Tinnitus
	____ Ear Pain	____ Vertigo
Respiratory	____ Shortness of Breath	____ Cough
	____ Shortness of Breath at Rest	____ Wheezing
	____ Shortness of Breath with Activity	____ Blood in Sputum
	____ Pain with Breathing	____ Night Sweats
Cardiovascular	____ Chest Pain	____ Orthopnea
	____ Palpitations	____ Edema
	____ Claudication	____ PND - Wake up at Night Short of Breath
Gastrointestinal	____ Abdominal Pain	____ Constipation
	____ Nausea	____ Anorexia
	____ Diarrhea	____ Trouble Swallowing
	____ Heartburn	____ Indigestion
	____ Vomiting	
Genitourinary	____ Urinary Urgency	____ Urinary Hesitancy
	____ Urinary Burning or Pain	____ Foamy Urine
	____ Blood in Urine	____ Incontinence
	____ Urinary Frequency	____ Nocturia - Wake up at Night to Urinate
Musculoskeletal	____ Back Pain	____ Muscle Pain
	____ Neck Pain	____ Arm Weakness
	____ Joint Pain	____ Leg Weakness
Skin	____ Rash	____ Dryness
	____ Itching	____ Color Change
	____ Scaling	
Neurological	____ Numbness	____ Tingling
	____ Tremors	____ Fainting
	____ Seizures	
Psychiatric	____ Depression	____ Anxiety
	____ Insomnia	
Endocrine	____ Heat Intolerance	____ Excessive Thirst
	____ Cold Intolerance	____ Excessive Urination
Hematology	____ Bleeding Gums	____ Easy Bruising
Immuno/Allergy	____ Seasonal Allergies	____ Hives
Other	_____	

Physician Notes

Please check if any blood relative has had:

Disease	Mother	Father	Sibling	Children
Kidney Disease				
Diabetes				
Stroke				
Heart Disease				
Heart Attack				
Hypertension				
Cancer				
Thyroid				
Tuberculosis				

Primary Care Doctor: _____

Date of Last Flu Shot: _____

Date of Last Pneumonia Shot: _____

Do you have a Medical Power of Attorney? _____ Yes _____ No

If yes, who is your healthcare agent or surrogate decision maker? _____

Please bring your Medical Power of Attorney to your next visit.

SOCIAL HISTORY

Marital Status: Please Circle

Married Single Divorced Separated Widowed

Occupation: _____

Coffee _____ Cups Per Day

Tea _____ Cups Per Day

Soft Drinks _____ Per Day/Per Week

Beer _____ Per Day/Per Week

Alcoholic Beverages _____ Per Day/Per Week

Do you smoke? _____Yes _____ No

If you did smoke, date you quit _____

Cigarettes _____ packs/day for _____ years

Do you smoke a pipe/cigar? _____Yes _____ No

Do you use smokeless tobacco? _____ Yes _____ No

Do you take any of the following:

Advil/Aleve ____ Yes ____ No

NSAIDS ____ Yes ____ No

Ibuprofen ____ Yes ____ No

Herbal Supplements ____ Yes ____ No