

FRESNO NEPHROLOGY MEDICAL GROUP, INC.

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Patient Name: _____

Date: _____

Y N Social History:

<input type="checkbox"/>	Smoking (how many years and how many packs a day)	
<input type="checkbox"/>	Alcohol/wine/beer	# How many?
<input type="checkbox"/>	Drugs (not prescribed by a Doctor)	
<input type="checkbox"/>	Married	# Children
<input type="checkbox"/>	Occupation	

Review of Systems:

General: _____ Date Description

<input type="checkbox"/>	Weight Loss/gain		
<input type="checkbox"/>	Tiredness		
<input type="checkbox"/>	Fatigue		
<input type="checkbox"/>	Loss of appetite		

Ears/eyes/nose/throat:

<input type="checkbox"/>	Glaucoma/cataract		
<input type="checkbox"/>	Sneezing/allergies		
<input type="checkbox"/>	Bleeding nose		
<input type="checkbox"/>	Sore throat		
<input type="checkbox"/>	Redness of eyes		

Cardiovascular:

<input type="checkbox"/>	Chest pain		
<input type="checkbox"/>	Shortness of breath		
<input type="checkbox"/>	Dizziness		
<input type="checkbox"/>	Palpitations/racing heart		

Pulmonary:

<input type="checkbox"/>	Cough		
<input type="checkbox"/>	Phlegm		
<input type="checkbox"/>	Blood in sputum		
<input type="checkbox"/>	Pneumonia		

Gastrointestinal:

<input type="checkbox"/>	Heart burn		
<input type="checkbox"/>	Nausea		
<input type="checkbox"/>	Vomiting		
<input type="checkbox"/>	Diarrhea		
<input type="checkbox"/>	Abdominal pain		
<input type="checkbox"/>	Constipation		
<input type="checkbox"/>	Blood in stool		

Genitourinary:

<input type="checkbox"/>	Pain on urination		
<input type="checkbox"/>	Frequent urination		
<input type="checkbox"/>	Blood in urine		
<input type="checkbox"/>	Foamy urine		
<input type="checkbox"/>	Number of times of urination at night		
<input type="checkbox"/>	Menstruation problems		

Musculoskeletal:

<input type="checkbox"/>	Back pain		
<input type="checkbox"/>	Joint pains		
<input type="checkbox"/>	Use of over the counter pain meds		
<input type="checkbox"/>	Leg swelling		