

FRESNO NEPHROLOGY MEDICAL GROUP, INC.

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Patient Name: _____ **Date:** _____

Y N Neurological:

<input type="checkbox"/>	<input type="checkbox"/>	Weakness		
<input type="checkbox"/>	<input type="checkbox"/>	Nerve pain		
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty swallowing		
<input type="checkbox"/>	<input type="checkbox"/>	Balance problem		

Endocrine:

<input type="checkbox"/>	<input type="checkbox"/>	Weight gain or loss		
<input type="checkbox"/>	<input type="checkbox"/>	Any hormonal supplements		

Psychiatric: Date Treating M.D. Description

<input type="checkbox"/>	<input type="checkbox"/>	Depression			
<input type="checkbox"/>	<input type="checkbox"/>	Psychosis			
<input type="checkbox"/>	<input type="checkbox"/>	Anxiety			
<input type="checkbox"/>	<input type="checkbox"/>	Sleep problems			

Hematological:

<input type="checkbox"/>	<input type="checkbox"/>	Blood transfusion		
<input type="checkbox"/>	<input type="checkbox"/>	Bruises		

Skin:

<input type="checkbox"/>	<input type="checkbox"/>	Rash		
<input type="checkbox"/>	<input type="checkbox"/>	Other skin lesions		
<input type="checkbox"/>	<input type="checkbox"/>	Hair loss		
<input type="checkbox"/>	<input type="checkbox"/>	Facial rash		

Dietary: (Daily)

Do you have high protein intake?(How much of these do you eat daily?)

A) Animal protein

<input type="checkbox"/>	<input type="checkbox"/>	Poultry
<input type="checkbox"/>	<input type="checkbox"/>	Fish
<input type="checkbox"/>	<input type="checkbox"/>	Beef
<input type="checkbox"/>	<input type="checkbox"/>	Pork

B) Supplements: (Please List)

<input type="checkbox"/>	<input type="checkbox"/>	Calcium
<input type="checkbox"/>	<input type="checkbox"/>	Vitamins:

C) Other:(How much daily?)

<input type="checkbox"/>	<input type="checkbox"/>	Citrus
<input type="checkbox"/>	<input type="checkbox"/>	Spinach, Nuts, Tea, Chocolate
<input type="checkbox"/>	<input type="checkbox"/>	Water
<input type="checkbox"/>	<input type="checkbox"/>	Salt
<input type="checkbox"/>	<input type="checkbox"/>	Soda/Cola's
<input type="checkbox"/>	<input type="checkbox"/>	Dairy Products
<input type="checkbox"/>	<input type="checkbox"/>	Fastfood, do you eat out frequently?