

Date of Visit \_\_\_\_\_

## Pediatric Nephrology Follow up Visit History Form

Patient Name \_\_\_\_\_ DOB \_\_\_\_\_

Primary Care Physician \_\_\_\_\_

\*\*\*Since your last visit:

### Medical

New medical problems? \_\_\_\_\_

\_\_\_\_\_  
New Doctors/Change in current doctor? \_\_\_\_\_

New medications? \_\_\_\_\_

\_\_\_\_\_  
New allergies? \_\_\_\_\_

New pharmacy? \_\_\_\_\_

### Social History

Updates to family history: \_\_\_\_\_

\_\_\_\_\_  
Changes in school or at home: \_\_\_\_\_

### Review of Systems:

Check any recent problems noted **and** explain:

**General:** weight loss weight gain fever loss of appetite decreased energy other

\_\_\_\_\_  
**Eyes:** tearing redness discharge other

\_\_\_\_\_  
**Ears:** pain discharge pulling at ears hearing loss other

\_\_\_\_\_  
**Nose/Mouth/Throat:** runny nose sore throat mouth sores problem swallowing other

\_\_\_\_\_  
**Cardiovascular:** palpitations fast heart rate chest pain swelling in legs, face or hands

\_\_\_\_\_  
**Respiratory:** cough wheezing shortness of breath bloody cough

\_\_\_\_\_  
**Gastroenterology:** nausea vomiting constipation diarrhea decreased appetite  
increased appetite abdominal pain blood in stool frequent soiling

\_\_\_\_\_  
**Urology:** pain on urination blood in urine foamy urine cloudy urine bedwetting  
problems urinating daytime wetting incontinence

\_\_\_\_\_  
**Musculoskeletal:** weakness joint pain muscle aches swelling joints

\_\_\_\_\_  
**Skin:** rash redness pallor itching masses

\_\_\_\_\_  
**Neurology:** headache confusion dizziness lightheadedness fainting

\_\_\_\_\_  
**Psychiatric:** depression anxiety mood swings sleep problems disorientation

\_\_\_\_\_  
**Endocrine:** excessive thirst cold/heat intolerance frequent urination

\_\_\_\_\_  
**Hematology/Lymphoma:** excessive bleeding anemia bruising swollen glands  
enlarged lymph nodes

\_\_\_\_\_  
**Allergy:** recurrent infections hay fever

\_\_\_\_\_