

Chronic Kidney Disease Patient Questionnaire

You have most likely been referred to this clinic by a health care professional or yourself to address concerns about impaired kidney function. This is a short questionnaire designed to help your doctor fully evaluate and manage your kidney health.

Section I: Kidney Disease

1. Have you ever been told you have kidney disease? Y / N (If no, skip to next section)
2. How long has it been since you were first diagnosed? (Circle one) < 1 year / 1-3 years / 3-5 years / 5-10 years / > 10 years
3. How was this diagnosed? (Check those that apply)
 - Blood test (elevated creatinine)
 - Protein in the urine
 - Other: _____
4. Have you been told what caused your kidney disease (e.g. diabetes, high blood pressure, glomerulonephritis, kidney stones, medication, related to surgery or severe medical illness)?

5. Have you ever had any of the following (Check if yes):
 - Kidney problems at birth or in childhood?
 - Hospitalization due to kidney failure?
 - Kidney failure while hospitalized for another reason?
 - Kidney stones?
 - Bladder or kidney infections?
 - Difficulty emptying your bladder?
 - Bladder or other urologic surgery?
 - Radiation to the abdomen or pelvis?
 - Chemotherapy for cancer?
 - Family history of kidney disease?
 - Blood in the urine?
 - Foamy urine?

If you answered yes to any of the above, please enter more details here:

Section II: Medications

1. Do you use regularly pain or antiinflammatory medicines or NSAIDS (i.e. Aleve, naproxen, ibuprofen, Motrin)? Y / N
 - a. If yes, how often? at least daily / 3 times per week / once a week / once a month

2. Do you use herbal supplements? Y / N
 - a. If yes, list them here please:

Section III: High blood pressure

1. Do you have high blood pressure or take medicine for high blood pressure? Y / N (If no, skip to next section).
2. How long ago were you first diagnosed? < 1 year / 1-3 years / 3-5 years / 5-10 years / > 10 years
3. Do you check your blood pressure at home? Y / N
4. If yes, how often? Daily / several times per week / once per week / once per month)
5. How often is your blood pressure greater than 140/90?
Most of the time / occasionally / never
6. Do you add salt to your food? No / occasionally / often / with each meal
7. Do you eat canned or processed food? No / occasionally / few times a week / every day
8. If you exercise, how often? at least daily / 3 times per week / once a week / once a month
9. Do you snore? Y / N
10. If yes, are you sleepy during the daytime or take frequent naps? Y / N
11. Have you ever been hospitalized for high blood pressure? Y / N
12. Have you had a stroke? Y / N
13. Do you have heart failure? Y / N
14. Have you had a heart attack? Y / N
15. Have you had a surgery for arteries supplying the legs? Y / N

Section IV: Diabetes

1. Have you ever been told you have diabetes or prediabetes? Y / N (If no, skip to next section)
2. How long ago were you first diagnosed? < 1 year / 1-3 years / 3-5 years / 5-10 years / > 10 years
3. Do you take or have you ever taken pills for diabetes? Y / N
 - If yes, how many years did you take it? < 1 / 1-5 / 5-10 / > 10
 - If you have stopped taking, how long ago did you stop (yrs)? < 1 / 1-5 / 5-10 / > 10
4. Do you take or have you ever taken insulin? Y / N
 - If yes, how many years did you take it? < 1 / 1-5 / 5-10 / > 10
 - If you have stopped taking, how long ago did you stop (yrs)? < 1 / 1-5 / 5-10 / > 10
5. How well have you blood sugars been controlled? Usually < 100 / 100-150 / 150-200 / > 200 / I don't check them
6. Do you have eye disease from diabetes? Y / N
7. Have you had laser treatment for your eyes? Y / N
8. Do you have numb feet? Y / N

Section V: Anemia

1. Have you ever been told you were anemic, had a low blood or hemoglobin count?
Y / N (If no, skip to next section).
2. How long ago were you first diagnosed? < 1 year / 1-3 years / 3-5 years / 5-10 years / > 10 years
3. Have you had to take medication to prevent anemia? Y / N

If yes what type:

Folate or folic acid Y / N

Dose: _____

Iron (pills or injections) Y / N

Dose: _____

Vitamin B12 Y / N

Dose: _____

Epogen or Aranesp Y / N

Dose: _____

4. Do you have any black stools? Y / N
5. Do you have any bright red blood in your stool? Y / N
6. Do you have any blood in your urine? Y / N
7. If female, do you still menstruate? Y / N

If yes, how often: _____

8. Do you have a family history of anemia? Y / N

If yes, please explain below:

9. Have you ever been diagnosed with the following:

Lymphoma Y / N

Leukemia Y / N

Vomiting blood Y / N

Stomach ulcers Y / N

Recurrent nosebleeds Y / N

Any other cancers:

Section VI: Bone disease

1. Have you ever been told you had osteoporosis, osteopenia, brittle, thin or weak bones? Y / N (If no, skip to the next section)
2. When were you told you had osteoporosis, osteopenia, brittle, thin or weak bones? < 1 year / 1-3 years / 3-5 years / 5-10 years / > 10 years
3. How was it diagnosed:

Bone scan Y / N

Broken bones Y / N

Other: _____

4. Do you take any medication for your bones? Y / N

If yes, what type:

Calcium Y / N
Dose: _____

Vitamin D Y / N
Dose: _____

Calcium and Vitamin D combination: Y / N
Dose: _____

Bisphosphates: Y / N

If yes, which medication:

Aredia (pamidronate) Y / N

Fosamax (alendronate) Y / N

Boniva (ibandronate) Y / N

Actonel (risedronate) Y / N

Zometa (zoledronate) Y / N

Other: _____

Section VII: Summary

1. If you answered yes to any of the above please enter any details you feel pertinent here.

2. Do you have any specific concerns regarding your kidney disease that you would like to have addressed today?
