



NY HEALTH KIDNEY SPECIALISTS

Nephrology & Hypertension Specialists

2500 Nesconset Highway, Bldg. #14A

Stony Brook, NY 11790

Tel: (631) 689-7800

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nyhealth.com

KIDNEY STONE PATIENT QUESTIONNAIRE, page 1

Patient's Name: _____ **Date:** _____

Kidney Stone History:

1. Has a "stone analysis" ever been performed on stones you have passed? _____

If so, by whom? _____

2. How many stones have you passed? _____

3. Have you had surgical procedures to remove the stones (i.e. lithotripsy)? _____

Please give dates. _____

4. Did you have pain with kidney stones? _____

Can you describe the nature and location of the pain? _____

Did you have pain when you urinated? _____

Did you see blood in the urine? _____

5. Do you have a family history of kidney stones?

If so, please state. _____

6. Do you have a history of frequent urinary tract infections? _____

If so, how many occurrences per year? _____

MEDICAL PROBLEMS

Have you ever been diagnosed with the following? (If so, please circle.)

1. gout

2. inflammatory bowel disease

3. chronic diarrhea

4. surgery which removed a portion of intestine

5. sarcoidosis

6. weight loss surgery

7. hyperparathyroidism



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Can you list any other medical conditions that your physician(s) has diagnosed?

MEDICATIONS Do you take any of the following medications? Please circle.

1. Triamterene
2. Lasix (Furosemide)
3. Bumex
4. Acetazolamide (Diamox)
5. Theophylline
6. Antacids
7. Vitamin A
8. Vitamin D
9. Vitamin C

Do you take any other medications? If so, please list _____

Do you have any allergies to medications? _____

DIETARY

Do you eat below foods, or drink below beverages and if so how frequently?:

(Indicate Yes or No)

Chocolate _____

Coffee _____

Tea _____

Juices (What types?) _____

Spinach or other dark greens _____

Nuts _____

Do you follow any salt restrictions? _____

Do you follow any fat restrictions? _____

Do you drink more than 8 glasses of fluid per day? _____

What type of fluids do you drink? _____

PERSONAL HISTORY

Do you smoke cigarettes? _____

Do you drink alcohol? _____

Do you exercise? If so, how often? _____

Thank you.