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KIDNEY STONE PATIENT QUESTIONNAIRE,

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

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.