

**For Patients Visiting the Department of Nephrology**

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| --- | --- |
| Name : | Age : |
| Email address : | Tel： |

1. **When did you start seeing a doctor for kidney disease?** (  years old)
2. **What kind of explanation do you receive about kidney disease from your doctor?**
3. **Are there any major illnesses you have had in the past or are currently being treated at the hospital?**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Disease | | Age |  | Surgical name |  | Name of treatment facility |  | |
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| **4.** | **Do you have allergies?**     No | |  | | | | |
|  |  Yes. ⇒ □ drugs ( | | ） | | | | |
|  | □ food ( | | ） | | | | |
|  | □ Other ( hay fever, antiseptic, | | ） | | | | |
|  |  |  |  |  |  |  |  | |

1. **Have you ever received nutritional guidance?**

□ Received

Did you get it sometime? ( )

Where did you get it? ( )

□ Never received

1. **Smoking**

□ Never smoked

□ Smoked before. From ( ) years old To ( ) years old, ( ) cigarettes/day,

□ Smoke ( ) cigarettes/day for ( ) years

1. **Drinking**

□ Do not drink

□ Drink often Type ( ) , ( )Times/week, ( ) / ml per day

1. **Movement**

□ Types

□ Frequency ( ) times / Week, ( ) hours / 1 time

1. **Are there any drugs, supplements, health foods, herbal medicines, etc. other than the medicines prescribed by our hospital?**

□ NOT

□ Type/Product Name （ ）

1. **Rest and sleep**

□ Enough

□ Insufficient (sleeping time \_\_\_\_\_\_\_\_\_\_\_ hours )

1. **Do you have any disabilities in your daily life?**

□ None

□ Yes , specifically ( )

**Thanks for your cooperation!**