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Name: _____
Date: _____
Date of birth: _____

STONE HISTORY

1. Is this your first stone? Yes _____ No _____
2. Stone on Right Side _____? Left Side _____?
3. How long have you known about this stone? Month _____ Year _____
4. If No to question #1:
In the past:
 Total number of stones on – Right _____ Left _____ Unknown _____
 Number of stones passed without intervention on – Right _____ Left _____ Unknown _____
 Number of stones basketed on – Right _____ Left _____ Unknown _____
5. Please list all surgeries for stone or kidney disease. (Include kidney and ureteral surgery) -
 Percutaneous Nephrostomy (PERC) on – Right _____ Left _____ Dates _____
 Ureterscopy on – Right _____ Left _____ Dates _____
 ESWL on – Right _____ Left _____ Dates _____
6. Any previous kidney injury? Yes _____ No _____
7. Any previous kidney infection? Yes _____ No _____
 Additional Comments: _____
8. Have you been treated for having any of the following:
 () hyperparathyroidism () hypercalciuria
 (excessive parathyroid function) (excessive urinary calcium)
 () hyperthyroidism () cystinuria
 (excessive thyroid function) (excessive urinary cystine)
 () renal tubular acidosis (RTA) () long-standing urinary infection
 () sarcoidosis () medullary sponge kidney
 () other (please detail) () gout
9. Have any previous stones been analyzed? Yes _____ No _____
 If yes, composition: Calcium _____ Struvite _____ Uric Acid _____ Cystine _____
10. Any family members with kidney stones? Yes _____ No _____
 If yes, circle appropriate relatives: Parents Grandparents Siblings Children

Please complete the following:

Pacemaker Yes _____ No _____
 Pregnant Yes _____ No _____
 Renal Failure Yes _____ No _____
 Heart Disease Yes _____ No _____
 Diabetes Yes _____ No _____
 Neurological Disease Yes _____ No _____
 Height _____ Weight _____

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