



IU Health Physicians

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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 check if you are on any of the following medications:

Aspirin _____
Coumadin _____
Dicumerol _____
Persantine _____
Anti-arthritis Medication _____
Cortisone _____
Insulin _____

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 _____