**KIDNEY DISEASES SCREENING QUESTIONNAIRE**

**Name of Client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Staff number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Age: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Gender: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Contact Numbers: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |
| --- | --- | --- |
| **Please Tick [ √] the Applicable Box**  | **Yes** | **No** |
| Do you have a family history of kidney failure, diabetes, or high blood pressure? |  |  |
| Do you have Heart Disease, High blood pressure, Diabetes, Lupus or any autoimmune disorders, chronic urinary infections or kidney stones? |  |  |
| Are you feeling fatigued or weak? |  |  |
| Are there changes in the colour or amount of your urine? |  |  |
| Is your urine foamy, pink or dark urine (blood in urine)? |  |  |
| Do you have increased thirst? |  |  |
| Do you have increased need to urinate (especially at night)? |  |  |
| Are your eyes Puffy? |  |  |
| Is your face, hands, abdomen, ankles, feet swollen? |  |  |
| Do you have persistent body itching? |  |  |
| Do you have chest pains and/or shortness of breath? |  |  |
| Do you suffer from a decrease in mental sharpness? |  |  |
| Are experiencing sleeping problems? |  |  |

 **Please visit UNISA Campus Clinic for the following free screening tests**:

**Blood pressure:**

**Blood glucose:**

**Blood cholesterol:**

**Urinalysis:**