Florida Medical Clinic

NEPHROLOGY • HEALTH HISTORY

CONFIDENTIAL

PATIENT NAME: _____ DATE OF BIRTH: _____ DATE: _____

LIST ANY MEDICATION ALLERGIES AND THE REACTION: _____

REACTION: _____

WHAT IS THE REASON YOUR DOCTOR SENT YOU TO SEE A KIDNEY SPECIALIST? _____

WHEN DID THE PROBLEM START? _____

PLEASE ✓ IF YOU HAVE EVER HAD ANY OF THE FOLLOWING. USE THE _____ SPACE TO PROVIDE DETAILS AND / OR YEAR OF ONSET.

KIDNEY DISEASE HISTORY

☐ **CKD (chronic Kidney Disease):**

☐ Stage 1 ☐ Stage 4

☐ Stage 2 ☐ Stage 5

☐ Stage 3 ☐ Unknown

☐ **Kidney Transplant:** Year: _____

Type: ☐ Cadaveric ☐ Living Related ☐ Living Unrelated

☐ **Dialysis:** Year Started? _____ Year Stopped? _____

Type: ☐ Hemodialysis ☐ Peritoneal Dialysis

☐ **Polycystic Kidney Disease**

☐ **Acute Kidney Injury or Acute Renal Failure**

Details (including year): _____

_____

☐ **Glomerulonephritis**

☐ **PROTEIN IN URINE (PROTEINURIA)**

DIABETES

☐ Diabetes Type 1

☐ Diabetes Type 2

☐ Diabetes Type Unknown

What year were you first told of this diagnosis? _____

☐ **HIGH BLOOD PRESSURE**

What year were you first told of this diagnosis? _____

☐ **STROKE**

Year: _____

☐ **GOUT**

CANCER

☐ Lung _____ ☐ Lymphoma _____

☐ Breast _____ ☐ Kidney _____

☐ Prostate _____ ☐ Thyroid _____

☐ Colon _____ ☐ Leukemia _____

☐ Melanoma _____ ☐ Endometrial _____

☐ Bladder _____ ☐ Pancreatic _____

☐ Other: _____

CARDIOVASCULAR

☐ Atrial Fibrillator

☐ Pacemaker

☐ AICD

☐ Valvular Heart Disease or Heart Murmur

☐ Congestive Heart Failure

ISCHEMIC HEART DISEASE

☐ Heart Attack Year: _____

☐ Angina / Chest Pain

☐ Angioplasty Year: _____

☐ Coronary Stent Year: _____

☐ CABG (Bypass Surgery) Year: _____

GENITOURINARY

☐ Enlarged Prostate or Prostate Problems

☐ Kidney Stones

☐ Frequent Bladder or Kidney Infections

_____

Physician Signature

INITIALS: _____ DATE OF BIRTH: _____

PAST MEDICAL HISTORY

PUMONARY

☐ COPD
☐ Asthma
☐ Tuberculosis
☐ Sleep Apnea

GASTROINTESTINAL

☐ GERD (Gastric Reflux)
☐ Stomach / Bowel Ulcers
☐ Hepatitis
☐ Chron's Disease
☐ Ulcerative Colitis

BLOOD DISEASE

☐ Anemia
☐ Sickle Cell Disease
☐ Blood Transfusion

IMMUNE SYSTEM

☐ HIV
☐ AIDS
☐ Rheumatoid Arthritis
☐ Lupus
☐ Prednisone Use (Steroid)

OB HISTORY (FEMALES)

☐ Preeclampsia
☐ Pregnancy Induced Hypertension
☐ Gestational Diabetes
☐ History of Complicated Pregnancy
☐ Miscarriages

OTHER

☐ Osteoarthritis
☐ Osteoporosis

☐ Multiple Sclerosis
☐ Seizures
☐ Parkinson's
☐ Dementia

☐ Depression
☐ Anxiety Disorder

☐ Thyroid Disease

SURGERY HISTORY

☐ Prostatectomy Year: _____
☐ Nephrectomy (Kidney Removal) Year: _____
☐ Kidney Stone Procedures Year: _____
☐ Renal Transplant Year: _____
☐ AV Fistula or Graft for Dialysis (Circle) Year: _____
☐ Dialysis Catheter Year: _____
☐ CABG / Bypass Year: _____
☐ Carotid Endarterectomy Year: _____
☐ Heart Valve Replacement Year: _____
☐ Cholecystectomy Year: _____
☐ Appendectomy Year: _____
☐ Gastric Bypass Year: _____
☐ Hysterectomy Year: _____
☐ Thyroid Surgery Year: _____
☐ Hip Replacement Year: _____
☐ Left ☐ Right ☐ Bilateral
☐ Knee Replacement Year: _____
☐ Left ☐ Right ☐ Bilateral
☐ Other: Year: _____
Year: _____
Year: _____

IMMUNIZATIONS (DATE / YEAR)

Pneumovax _____

Flu Vaccine _____

PREVENTION (DATE / YEAR)

Mammogram _____

Pelvic / Pap _____

Colonoscopy _____

Check for blood in the stool _____

Rectal exam _____

INITIALS: _____ DATE OF BIRTH: _____

REVIEW OF SYSTEMS

Mark if any of these symptoms are **new to you within the PAST 3 MONTHS**

GENERAL

☐ Fever
☐ Weight Gain
☐ Weight Loss
☐ Fatigue
☐ Chills

HEENT

☐ New Vision Impairment
☐ Eye Pain
☐ Conjunctivitis
☐ Double Vision
☐ Hearing Loss
☐ Nose Bleeds
☐ Headache
☐ Hoarseness
☐ Vertigo

REPIRATORY

☐ Shortness of breath
☐ Shortness of breath at rest
☐ Shortness of breath w/activity
☐ Pain with breathing
☐ Cough
☐ Wheezing
☐ Blood in Sputum
☐ Night Sweats

MUSCULOSKELETAL

☐ Joint Swelling

CARDIOVASCULAR

☐ Chest Pain
☐ Palpitations
☐ Claudication or leg pain while walking
☐ Swollen Ankles

How many pillows do you use to sleep? _____

GASTROINTESTINAL

☐ Abdominal Pain
☐ Nausea (persistent)
☐ Diarrhea
☐ Vomiting
☐ Constipation
☐ Loss of appetite
☐ Trouble swallowing
☐ Black stools

GENITOURINARY

☐ Urinary burning or pain
☐ Blood in urine
☐ Difficulty urinating
☐ Foamy urine
☐ Incontinence (urinary)

How many times do you wake up at night to urinate? _____

SKIN

☐ Rash
☐ Skin Color Change

ENDOCRINE

☐ Heat Intolerance
☐ Cold Intolerance
☐ Excessive Thirst
☐ Excessive Urination

NEUROLOGICAL

☐ Neuropathy
☐ Seizures
☐ Fainting

PSYCHIATRIC

☐ Depression
☐ Anxiety

PHYSICIAN COMMENTS

_____

_____

_____

_____

SOCIAL HISTORY

CURRENT MARITAL STATUS

☐ Married ☐ Separated ☐ Single ☐ Widowed ☐ Divorced

LIVING ARRANGEMENT

☐ Alone ☐ Spouse ☐ Significant Other
☐ Family Member ☐ In home caregiver ☐ Assisted Living Facility

OCCUPATION

☐ Retired
☐ Unemployed
☐ Student
☐ Employed: ☐ Full Time ☐ Part Time

Current Occupation: _____

SOCIAL HISTORY - HABITS

TOBACCO USE

☐ Current or former user ☐ Never used ☐ Unknown

☐ Cigarettes ☐ Chewing Tobacco ☐ Pipes ☐ Snuff ☐ Cigars

If a former user, what year did you quit? _____

If a current or former smoker, how often do / did you smoke? ☐ Every Day ☐ Some Days ☐ Unknown

How many packs per day do / did you smoke? _____

How many total years have you used cigarettes? _____

INITIALS: _____ DATE OF BIRTH: _____

SOCIAL HISTORY - HABITS (Continued)

ALCOHOL USE ☐ Current or former user ☐ Never used ☐ Occasional Alcohol (Social)

☐ 1 -2 per day ☐ 3 or more per day

If a former user, what year did you quit? _____

RECREATIONAL DRUG USE ☐ Current user ☐ Former user: Year Quit _____ ☐ Never used

☐ Marijuana ☐ Heroin ☐ Cocaine

☐ Amphetamines ☐ Ecstasy ☐ Barbituates

☐ LSD ☐ Opium ☐ Other _____

Other Social History Not Listed Above: _____

_____

_____

_____

FAMILY HISTORY

DO THE FOLLOWING FAMILY MEMBERS HAVE ANY OF THE FOLLOWING MEDICAL CONDITIONS?

KIDNEY DISEASE	☐ Father	☐ Mother	☐ Sibling	☐ Child
DIABETES	☐ Father	☐ Mother	☐ Sibling	☐ Child
HIGH BLOOD PRESSURE	☐ Father	☐ Mother	☐ Sibling	☐ Child
ISCHEMIC HEART DISEASE	☐ Father	☐ Mother	☐ Sibling	☐ Child
CANCER **Type: _____**	☐ Father	☐ Mother	☐ Sibling	☐ Child
STROKE	☐ Father	☐ Mother	☐ Sibling	☐ Child
ADULT POLYCYSTIC KIDNEY DISEASE	☐ Father	☐ Mother	☐ Sibling	☐ Child

FAMILY HISTORY - STATUS

Father: ☐ Living ☐ Deceased ☐ Unknown Age at death: _____ Cause of death: _____

Mother: ☐ Living ☐ Deceased ☐ Unknown Age at death: _____ Cause of death: _____

Other Pertinent Family History Not Listed Above:

_____

_____

_____