Health History

Patient Name: ____MR#: ________________________

Date of Birth: __________________ Age: __________________ Sex: M _______ F _______

Home Phone: ___________________________ Work Phone: _______________________________

How did you learn about Dallas Nephrology Associates?:
PCP: ______ Specialist: ______ Relative / Friend: ______
Internet Search: ______ TV/Radio: ______ Other: ______

Referring Physician (s): ____

Reasons for referral to this office: ____

Please list the names of all physicians you currently see: ____
____ ____
____ ____

MEDICATIONS

List all medications (including dose and how often you take it):

____ ____
____ ____
____ ____
____ ____
____ ____
____ ____
____ ____
____ ____
____ ____
____ ____

Please list all over the counter medications (examples: Tylenol, Advil) herbal supplements and vitamins you currently take: ____
____ ____
____ ____

Allergies: ____

PREVIOUS MEDICAL HISTORY

Do you have any of the following?

Hypertension (High Blood Pressure) Yes ____ No ___
If yes, for how long? ____
Diabetes Yes ____ No ___
If yes, for how long? ____
Heart Disease:
History of a heart attack Yes ____ No ___
If yes, when? ____
Atrial fibrillation Yes ____ No ___
Heart failure Yes ____ No ___
Pacemaker Yes ____ No ___
History of an angioplasty? Yes ____ No ___
If yes, when? ____
Any other heart condition? Yes ____ No ___
If yes, what? ____

List any surgeries____
____
____

List other illnesses____
____
____

SOCIAL / OCCUPATIONAL HISTORY

Married: _____ Single: _______ Divorced: _____ Widowed (er): _____ Separated: __________

Are you currently working? Yes ____ No ___ Your Occupation: __________________
Are you working full time? Yes ____ No ___ How many hours/day? ______________
Do you currently smoke? Yes ____ No ___ __________packs per day
Have you ever smoked? Yes ____ No ___ __________packs per day
How long have/did you smoke? ______________________
Have you ever used illegal drugs? Yes ____ No ___
What type of drugs have you used? ____
When did you last use drugs? ______________________
Do you currently consume alcoholic drinks? Yes ____ No ___
How many alcoholic drinks do you consume per day? _______ Per week? ________

FAMILY HISTORY

	Age	Medical Problems	Cause of Death/Age at death (If no longer alive)
Father	____	____________________	______________________________
Mother	____	____________________	______________________________
Brothers	____	____________________	______________________________
	____	____________________	______________________________
	____	____________________	______________________________
	____	____________________	______________________________
Sisters	____	____________________	______________________________
	____	____________________	______________________________
	____	____________________	______________________________
	____	____________________	______________________________
Sons	____	____________________	______________________________
	____	____________________	______________________________
	____	____________________	______________________________
Daughters	____	____________________	______________________________
	____	____________________	______________________________
	____	____________________	______________________________

Check if any of your blood relatives had any of the following:

Disease			**Relationship to you**
Diabetes	Yes ____	No ___	____________________________________
Heart Disease	Yes ____	No ___	____________________________________
Stroke	Yes ____	No ___	____________________________________
High Blood Pressure	Yes ____	No ___	____________________________________
Kidney Disease	Yes ____	No ___	____________________________________
Malignancy/Cancer	Yes ____	No ___	____________________________________

SYSTEMS REVIEW

CONSTITUTIONAL *Check any that apply to you...*

Recurrent Fevers? Yes ____ No ___
Chills or Night Sweats? Yes ____ No ___
Loss of Appetite? Yes ____ No ___

Your height is:_________________ Your current weight is: _______________

Is this your usual weight? Yes ____ No ___
Have you recently gained weight? Yes ____ No ___
Have you recently lost weight? Yes ____ No ___

Immunizations:

Hepatitis B?	Yes _____	No _____	When received? ______________
Pneumonia?	Yes _____	No _____	When received? ______________
Influenza?	Yes _____	No _____	When received? ______________
Shingles?	Yes _____	No _____	When received? ______________

EYE, EAR, NOSE, AND THROAT *Check any that apply to you...*

Blindness Yes ____ No ___
Glaucoma Yes ____ No ___
Diabetic Retinopathy Yes ____ No ___
Deafness/Hearing Loss Yes ____ No ___

PULMONARY (Lungs) *Check any that apply to you...*

TB/Tuberculosis/Positive TB skin test Yes ____ No ___
History of abnormal chest x-ray Yes ____ No ___
Shortness of breath Yes ____ No ___
Chronic Bronchitis Yes ____ No ___
Asthma Yes ____ No ___
Emphysema/COPD Yes ____ No ___
History of lung masses/nodules Yes ____ No ___
History of lung cancer Yes ____ No ___

CARDIAC (Heart) and **VASCULAR** (Circulation) *Check any that apply to you...*

Chest Pain Yes ____ No ___
Palpitations Yes ____ No ___
Poor Circulation Yes ____ No ___
Pain in Legs When Walking Yes ____ No ___
Ulcers on Feet Yes ____ No ___
Do you ever wake up at night short of breath? Yes ____ No ___
Do you have to sleep on extra pillows in order to breathe? Yes ____ No ___

GASTROENTEROLOGY (Abdomen/intestines/liver/stomach) *Check any that apply to you…*

Ulcer in stomach or intestines Yes ____ No ___
History of Polyps Yes ____ No ___
History of Blood in Stools Yes ____ No ___
Diverticulosis Yes ____ No ___
History of vomiting blood? Yes ____ No ___
Problems with swallowing? Yes ____ No ___
History of intestinal problems? Yes ____ No ___
Have you ever had a colonscopy (lower endoscopy)? Yes ____ No ___
When? ____________________ Why? ____________________
Have you ever had an EGD (upper endoscopy)? Yes ____ No ___
When? ____________________ Why? ____________________

NEPHROLOGY/UROLOGY (Kidney/bladder/ureter/urethra) *Check any that apply to you…*

History of Kidney Infections Yes ____ No ___
Kidney Stones Yes ____ No ___
Polycystic kidney disease? Yes ____ No ___
History of Enlarged Prostate Yes ____ No ___
Frequent Bladder Infections Yes ____ No ___
History of Bladder Surgeries Yes ____ No ___
If yes, why? ____
Do you get up during the night to urinate? Yes ____ No ___
If yes, how many times? ______________________________________
Do you have burning when you urinate? Yes ____ No ___
Do you see blood in your urine? Yes ____ No ___
Have you been told you have protein in your urine? Yes ____ No ___

QUESTIONS FOR FEMALE PATIENTS:

How many times have you been pregnant? ______________________________
How many living children do you have? ______________________________
How many miscarriages have you had? ______________________________

QUESTIONS FOR MALE PATIENTS:

Have you had loss of sexual interest? Yes ____ No ___
Do you have difficulty having an erection? Yes ____ No ___

MUSCULOSKELETAL *Check any that apply to you…*

Arthritis Yes ____ No ___
Joint Pain / Swelling Yes ____ No ___
Broken Bones Yes ____ No ___
Osteoporosis Yes ____ No ___

NEUROLOGY (Brain and Spinal Cord) *Check any that apply to you…*

Headaches Yes ____ No ___
Head Injury Yes ____ No ___
Seizures Yes ____ No ___
If history of seizures, please give date and cause: ___________________________
CVA (Stroke) Yes ____ No ___
Spinal Cord Injury Yes ____ No ___

ENDOCRINOLOGY (Diabetes or Thyroid) *Check any that apply to you…*

Do you have Diabetes?: Yes ____ No ___
Age when diagnosed ____________________
Treated with Insulin? Yes ____ No ___
Treated with Oral Agents? Yes ____ No ___
Thyroid nodule/masses Yes ____ No ___
Thyroidectomy/Thyroid surgically removed? Yes ____ No ___

HEMATOLOGY/ONCOLOGY/RHEUMATOLOGY *Check any that apply to you…*

History of Bleeding Problems Yes ____ No ___
History of Difficulty Clotting Yes ____ No ___
Hemophilia Yes ____ No ___
Sickle Cell Disease Yes ____ No ___
Amyloidoisis Yes ____ No ___
Systemic Lupus Erythematous Yes ____ No ___
Vasculitis Yes ____ No ___
Goodpasture's Disease Yes ____ No ___
History of swollen lymph nodes Yes ____ No ___
History of Cancer Yes ____ No ___
If yes, what type? ____
When was the cancer diagnosed? __________________________________
What treatment was done? _____________________________________
Have you ever had a blood transfusion? Yes ____ No ___

INFECTIONS *Check any that apply to you…*

HIV Yes ____ No ___
Hepatitis B Yes ____ No ___
Hepatitis C Yes ____ No ___
Lyme disease Yes ____ No ___
Any other serious infections? Yes ____ No ___
If yes, please list: ____

PSYCHOLOGICAL (Mental/Social) *Check any that apply to you…*

History of Mental Illness Yes ____ No ___
History of Alcohol/Substance Abuse Yes ____ No ___
Anxiety Yes ____ No ___
Depression Yes ____ No ___