DALLAS NEPHROLOGY ASSOCIATES
*Kidney Care Excellence Since 1971*

## HEALTH HISTORY

Patient Name: _____ MR#: _____

Date of Birth: _____ Age: _____ Sex: M _____ F _____

Home Phone: _____ Work Phone: _____ Email: _____

How did you learn about Dallas Nephrology Associates?

PCP _____ Specialist _____ Relative / Friend _____

Internet Search _____ Other _____

Referring Physician(s): _____ Phone: _____

_____ Phone: _____

Reason(s) for referral to this office: _____

Please list the names of all physicians you currently see:

_____ Phone: _____

_____ Phone: _____

_____ Phone: _____

_____ Phone: _____

_____ Phone: _____

_____ Phone: _____

## MEDICATIONS

Your Pharmacy: _____ Phone: _____

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

| Medication Name | Dosage | How often? |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

| | | |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

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

| OTC Medication Name | Dosage | How often? |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

**Known Drug 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:**

| Surgical Procedure | Date/Year | Surgeon/Physician Name |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

**List other illnesses:**

| Illness | Date/Year | Illness | Date/Year |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

## 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 ___ |

**ADDITIONAL COMMENTS**