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