SOUTH PALM BEACH NEPHROLOGY, P.A.

Health History

Patient Name: _____ MR#: _____

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

Home Phone: _____ Work Phone: _____

Referring Physician(s): _____

Reason 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):

Medication	*Dose*	*Frequency*	*Medication*	*Dose*	*Frequency*

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 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 per 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	_____	_____	_____
Brother(s)	_____	_____	_____
Brother(s)	_____	_____	_____
Brother(s)	_____	_____	_____
Brother(s)	_____	_____	_____
Sister(s)	_____	_____	_____
Sister(s)	_____	_____	_____
Sister(s)	_____	_____	_____
Sister(s)	_____	_____	_____
Sons(s)	_____	_____	_____
Sons(s)	_____	_____	_____
Sons(s)	_____	_____	_____
Daughters(s)	_____	_____	_____
Daughters(s)	_____	_____	_____
Daughters(s)	_____	_____	_____

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 *Check any that apply to you...*

CONSTITUTIONAL

Recurrent fevers ..... Yes____ No_____
Chills or Night Sweats ..... Yes____ No_____
Loss of Appetite ..... Yes____ No_____
Your height is:_____ Your 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 & THROAT

Blindness ..... Yes____ No _____
Glaucoma ..... Yes____ No _____
Diabetic Retinopathy ..... Yes____ No _____
Deafness/Hearing Loss ..... Yes____ No _____

PULMONARY

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) & VASCULAR (Circulation)

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 sleep on extra pillows in order to breathe?
Yes____ No _____

GASTROENTEROLOGY
(Abdomen/intestines/liver/stomach)

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)

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? _____

MUSCULOSKELETAL

Arthritis..... Yes ____ No ____

Joint Pain/Swelling..... Yes ____ No ____

Broken Bones ..... Yes ____ No ____

Osteoporosis ..... Yes ____ No ____

NEUROLOGY (Brain and Spinal Cord)

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)

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 ____

HEMATOLGY/ONCOLOGY/RHEUMATOLOGY

History of Bleeding problems... Yes ____ No ____

History of Difficulty Clotting ...Yes ____ No ____

Have you ever had a blood transfusion?
Yes ____ No ____

HEMATOLOGY/ONCOLOGY/RHEUMATOLOGY (Con't)

History of Cancer ..... Yes ___ No ____

If yes, what type? _____

When was the cancer diagnosed? _____

What treatment was done? _____

Sickle Cell Disease .....Yes ____ No ____

Amyloidosis ..... Yes ____ No ____

Systemic Lupus Erythematosus .. Yes ____ No ____

Vasculitis .....Yes ____ No ____

Good pasture's Disease ..... Yes ____ No ____

History of swollen lymph nodes..Yes ____ No ____

Hemophilia..... Yes ____ No ____

INFECTIONS

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)

History of Mental Illness .....Yes _____ No ____

History of Alcohol/Substance Abuse..... Yes _____ No ____

Anxiety .....Yes _____ No ____

Depression .....Yes _____ No ____

QUESTIONS FOR MALE PATIENTS:

Have you had loss of sexual interest? ..... Yes ____ No ____

Do you have difficulty having an erection?. Yes ____ No ____