



The Austin Diagnostic Clinic Nephrology
 North & South Austin, Bastrop, Cedar Park,
 Marble Falls, and Round Rock: 512/901-4010
 San Marcos & Luling: 512/805-0680

Patient History Form

Name _____

Date of Birth _____ Age _____

Primary Care Physician _____

Which doctor referred you here? _____

What is the reason your doctor sent you to see a
 Kidney specialist _____

How long have you known about this problem?

What other doctors have you seen for this problem?

What other doctors take care of you?

Check the following symptoms that you have/had

- | | |
|---|---|
| <input type="checkbox"/> blood in the urine | <input type="checkbox"/> urinate frequently |
| <input type="checkbox"/> protein in the urine | <input type="checkbox"/> pain on urination |
| <input type="checkbox"/> foamy urine | <input type="checkbox"/> urinary infection |
| <input type="checkbox"/> waking to urinate | <input type="checkbox"/> incontinence |
| <input type="checkbox"/> bedwetting | <input type="checkbox"/> kidney stones |
| <input type="checkbox"/> prostate problems | <input type="checkbox"/> kidney failure |

Past Medical History

Check the following illnesses that you have/had

- | | |
|--|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Nerve damage |
| <input type="checkbox"/> Heart failure | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Heart valve problem | <input type="checkbox"/> Bleeding probs |
| <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> High cholesterol | <input type="checkbox"/> GI bleeding |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> COPD | <input type="checkbox"/> Gallbladder |
| <input type="checkbox"/> GERD | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Sleep Apnea | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Spine disease |
| <input type="checkbox"/> Vascular disease | <input type="checkbox"/> Osteoporosis |

Explain any of the above problems or other
 Medical problems you may have. Include dates and
 treatments if possible.

Date _____

List any operations or surgeries

Current Medications (include over-the-counter medicines—tylenol, advil, ibuprofen, aleve, etc.)

List any medication Allergies

Family Medical History

Which family members have/had:

- Heart disease _____
 Diabetes _____
 High Blood Pressure _____
 Kidney disease _____
 Stroke _____
 Cancer _____
 Blindness _____
 Deafness _____
 Other _____

Social History

Single Married Divorced Widowed

Occupation _____

Previous occupation _____

With whom do you live? _____

Have you ever smoked? yes no

If so, for how long? _____

When did you quit? _____

Do you drink alcohol? _____

If so, how much? _____

When did you quit? _____

Immunizations—date/year received if completed

Pneumovax _____

Flu vaccine _____

Preventative--date/year performed if completed

Mammogram _____

Colonoscopy _____

Please Circle "Yes" or "No" to any of the following symptoms that are NEW to you:

GENERAL

- Yes No Chills
- Yes No Fever
- Yes No Night Sweats
- Yes No Poor Appetite
- Yes No Weight Loss
- Yes No Weight gain
- Yes No Loss of energy

EYES

- Yes No Sudden change in vision
- Yes No Double Vision
- Yes No Tearing
- Yes No Redness

EARS

- Yes No Sudden loss of hearing
- Yes No Ringing in the ears
- Yes No Ear ache
- Yes No Frequent ear infections

NOSE

- Yes No Nasal congestion
- Yes No Frequent sinus infections
- Yes No Frequent nose bleeds

MOUTH/THROAT

- Yes No Frequent throat infections
- Yes No Bleeding gums
- Yes No Change in voice
- Yes No Hoarseness

LUNGS

- Yes No Chronic Cough
- Yes No Coughing up blood
- Yes No Shortness of breath
- Yes No Wheezing
- Yes No Shortness of breath with activity

HEART

- Yes No Chest Pain or Pressure
- Yes No Heart Palpitations
- Yes No Irregular heart beat
- Yes No Waking up with shortness of breath
- Yes No Using several pillows to sleep
- Yes No Swelling of legs, ankles or feet
- Yes No Pain in calves when walking

STOMACH/INTESTINES

- Yes No Difficulty swallowing
- Yes No Painful swallowing
- Yes No Heartburn/indigestion
- Yes No Stomach discomfort/pain
- Yes No Nausea or vomiting
- Yes No Vomiting blood
- Yes No Blood in stools
- Yes No Constipation
- Yes No Chronic Diarrhea
- Yes No Do you use laxatives
- Yes No Black, tarry stools
- Yes No History of jaundice

ENDOCRINE

- Yes No Excessive thirst
- Yes No Cold/Heat intolerance
- Yes No Hot flashes

WOMEN

- Yes No Menopause
- Yes No Irregular periods
- Yes No Abnormal Vaginal bleeding
- Yes No Complicated Pregnancies
- Yes No Miscarriages

MEN

- Yes No Problems with impotence
- Yes No Prostate problems
- Yes No Weak or slow urinary stream

NERVOUS SYSTEM

- Yes No Severe headaches
- Yes No Hand Tremors
- Yes No Dizziness or Lightheadedness
- Yes No Loss of balance
- Yes No Seizures
- Yes No Passing out or fainting
- Yes No Numbness or tingling
- Yes No Paralyzed arm or leg
- Yes No Slurred Speech

BONES/MUSCLES/JOINTS

- Yes No Back Pain
- Yes No Painful Joints
- Yes No Swelling of the joints
- Yes No Stiff joints
- Yes No Muscle Aches
- Yes No Muscle weakness

SKIN

- Yes No Skin rash
- Yes No Skin discoloration
- Yes No Easy bruising
- Yes No Itching excessively
- Yes No Hair Loss
- Yes No Finger/Toe Nail changes
- Yes No Tattoos

BLOOD

- Yes No Anemia
- Yes No Blood Loss
- Yes No Have you had a blood transfusion

PSYCHIATRIC

- Yes No Mood Swings
- Yes No Depression
- Yes No Anxiety
- Yes No Sleep problems
- Yes No Hallucinations
- Yes No Memory Loss

Other issues _____
