



Date \_\_\_\_\_

## Patient History Form

Name \_\_\_\_\_

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? \_\_\_\_\_

- 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   |

Explain any of the above problems or other concerns you may have. Please include dates and treatments.

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

List any operations or surgeries

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

### Current Medications

(include over-the-counter medicines)

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

List any medication Allergies

\_\_\_\_\_  
 \_\_\_\_\_

### Family Medical History

*Which family members have/had:*

- |  |
|--|
| <input type="checkbox"/> Heart disease       |
| <input type="checkbox"/> Diabetes            |
| <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Kidney disease      |
| <input type="checkbox"/> Stroke              |
| <input type="checkbox"/> Cancer              |
| <input type="checkbox"/> Blindness           |
| <input type="checkbox"/> Deafness            |
| <input type="checkbox"/> 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? \_\_\_\_\_

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

**GENERAL**

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

**EYES**

- Yes No Sudden change in vision
- Yes No Double Vision
- Yes No Tearing or 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 or 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/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 or 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

**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