Jacksonville Nephrology, PA

Kidney Diseases and Hypertension

MEDICAL HISTORY FORM

PLEASE FILL OUT THE FORM AS ACCURATELY AS POSSIBLE.
THE INFORMATION WILL BE ENTERED INTO YOUR PERMANENT RECORD

NAME: _____ **DOB:** _____

A. DO YOU HAVE:	**YES**	**NO**	**M.D. NOTES**		**YES**	**NO**	**M.D. NOTES**
KNOWN KIDNEY DISEASE	☐	☐	_____	DIABETES IN EYES (Laser Treatment)	☐	☐	_____
URINATION AT NIGHT	☐	☐	_____	DIABETES IN NERVES (Neuropathy)	☐	☐	_____
FREQUENT URINATION	☐	☐	_____	PROSTATE INFECTION	☐	☐	_____
BURNING ON URINATION	☐	☐	_____	PAIN WITH WALKING (PAD/PVD)	☐	☐	_____
DIFFICULTY URINATING	☐	☐	_____	HEARING LOSS	☐	☐	_____
SINUSITIS	☐	☐	_____	KIDNEY/BLADDER INFECTION	☐	☐	_____
PROTEIN / FOAMY URINE	☐	☐	_____	HERBAL MEDICINES	☐	☐	_____
BLOOD IN URINE	☐	☐	_____	CHILDHOOD NEPHRITIS	☐	☐	_____
KIDNEY STONES	☐	☐	_____	CONSISTENT USE OF Non-Steroidal (Motrin, Ibuprofen, Aleve, Goody, Naproxen, Indocin, Mobic, Excedrin)	☐	☐	*SELECT*

B. LIST MEDICAL DIAGNOSIS AND SURGICAL HISTORY WITH APPROXIMATE YEAR:

Medical Diagnosis	Year
1.	
2.	
3.	
4.	
5.	
Surgical History	**Year**
7.	
8.	
9.	
10.	

C. LIST MEDICINES INCLUDING OVER THE COUNTER AND HERBALS AND/OR BRING TO CLINIC VISIT:

Medication with dose and frequency per day
1.
2.
3.
4.
5.
6.
7.
8.
9.
10.

D. ALLERGIES AND TYPE OF REACTION: _____

_____

E. FAMILY HISTORY:

	YES	NO	Relationship		YES	NO	Relationship
KIDNEY DISEASE	☐	☐	_____	DIABETES	☐	☐	_____
HEART ATTACK	☐	☐	_____	CANCER	☐	☐	_____
HIGH BLOOD PRESSURE	☐	☐	_____	STROKE	☐	☐	_____
GOUT	☐	☐	_____	LUPUS	☐	☐	_____
KIDNEY TRANSPLANT	☐	☐	_____	DIALYSIS	☐	☐	_____

MEDICAL HISTORY FORM

F. SOCIAL HISTORY:

HAVE YOU EVER SMOKED? YES ☐ NO ☐ PACKS PER DAY: _____ FOR _____ YEARS QUIT IN _____

DO YOU DRINK ALCOHOL? YES ☐ NO ☐ DRINKS PER DAY: _____ FOR _____ YEARS QUIT IN _____

ARE YOU: *SELECT* ☐ RETIRED OCCUPATION:_____

G. REVIEW OF SYMPTOMS (CHECK ANY THAT REGULARLY OCCUR):

GENERAL:
- ☐ FATIGUE
- ☐ FEVER
- ☐ CHILLS
- ☐ NIGHT SWEATS
- ☐ CHANGE IN APPETITE OR WEIGHT

HEART:
- ☐ HEART ATTACK
- ☐ IRREGULAR. OR RAPID HEART BEAT
- ☐ CHEST PAIN OR TIGHTNESS
- ☐ MURMUR
- ☐ TROUBLE LYING FLAT

ENDOCRINOLOGIC:
- ☐ THYROID DISEASE
- ☐ HOT/COLD SENSITIVITY
- ☐ EXCESSIVE WATER DRINKING

HEENT:
- ☐ MIGRAINES
- ☐ SEVERE HEADACHE
- ☐ LOSS OF CONSCIOUSNESS
- ☐ RINGING IN THE EARS
- ☐ BLURRY VISION
- ☐ DOUBLE VISION
- ☐ HAYFEVER/SINUSITIS
- ☐ NOSE BLEEDS
- ☐ FREQUENT SORE THROAT
- ☐ HOARSENESS

GASTROINTESTINAL:
- ☐ DIVERTICULI/HEMMORHOIDS
- ☐ ULCERS
- ☐ DIARRHEA
- ☐ CONSTIPATION
- ☐ VOMITING BLOOD
- ☐ LIVER DISEASE/HEPATITIS
- ☐ BLACK TARRY STOOL OR BLOOD IN STOOL
- ☐ TROUBLE SWALLOWING

HEMATOLOGIC:
- ☐ ANEMIA
- ☐ EASY BRUISING
- ☐ BLOOD TRANSFUSION
- ☐ SWOLLEN LYMPH GLANDS
- ☐ BLOOD CLOT

JOINT:
- ☐ SWOLLEN JOINTS
- ☐ WEAKNESS
- ☐ ARTHRITIS
- ☐ OSTEOPOROSIS
- ☐ BACK PAIN
- ☐ MUSCLE PAIN
- ☐ RASHES

PULMONARY:
- ☐ ASTHMA
- ☐ TUBERCULOSIS
- ☐ WHEEZING
- ☐ PERSISTENT COUGH
- ☐ COUGHING UP BLOOD
- ☐ UNRESOLVING PNEUMONIA
- ☐ SHORTNESS OF BREATH WITH EXERCISE
- ☐ ASBESTOS / SILICA CONTACT

NEUROLOGIC:
- ☐ SEIZURES
- ☐ NUMBNESS
- ☐ STROKE
- ☐ VERTIGO
- ☐ LOSS OF BALANCE
- ☐ PSYCHOLOGIC TREATMENT

OTHERS: _____

H. HAVE YOU HAD THE FOLLOWING VACINNES THIS SEASON (SEPT 1 – MARCH 31):

	YES	NO	DATE
INFLUENZA	☐	☐	_____
PNEUMONIA	☐	☐	_____

Notes (for office use only):

_____

_____

_____

_____