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
KNOWN KIDNEY DISEASE	☐	☐	_____
URINATION AT NIGHT	☐	☐	_____
FREQUENT URINATION	☐	☐	_____
BURNING ON URINATION	☐	☐	_____
DIFFICULTY URINATING	☐	☐	_____
SINUSITIS	☐	☐	_____
PROTEIN / FOAMY URINE	☐	☐	_____
BLOOD IN URINE	☐	☐	_____
KIDNEY STONES	☐	☐	_____
DIABETES IN EYES (Laser Treatment)	☐	☐	_____
DIABETES IN NERVES (Neuropathy)	☐	☐	_____
PROSTATE INFECTION	☐	☐	_____
PAIN WITH WALKING (PAD/PVD)	☐	☐	_____
HEARING LOSS	☐	☐	_____
KIDNEY/BLADDER INFECTION	☐	☐	_____
HERBAL MEDICINES	☐	☐	_____
CHILDHOOD NEPHRITIS	☐	☐	_____
CONSISTENT USE OF Non-Steroidal (Motrin, Ibuprofen, Aleve, Goody, Naproxen, Indocin, Mobic, Excedrin)	☐	☐	_____

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: SINGLE / MARRIED / DIVORCED / WIDOWED ☐ 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. DO YOU HAVE:

ADVANCE DIRECTIVES YES ☐ NO ☐ (If yes, please bring with you to appointment)

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

	YES	NO	DATE
INFLUENZA	☐	☐	_____
PNEUMONIA	☐	☐	_____

Notes (for office use only):

_____

_____

_____

_____