Patient Name:______________________ Patient DOB: ______________

MEDICAL HISTORY

Please mark YES or NO and fill in appropriate blanks as needed

Kidney Disease

Chronic Kidney Disease Yes ☐ No ☐

If yes, year diagnosed ______________

Previous Nephrologist ______________________________

Transplant Yes ☐ No ☐

If yes, date ______________

Donor type Living ☐ Deceased ☐

Related ☐ Unrelated ☐

Frequent Infections Yes ☐ No ☐

Polycystic Kidney Disease Yes ☐ No ☐

Any other kidney history we should know? ☐

Diabetes

Do you have Diabetes? Yes ☐ No ☐

If yes, type? Type 1 ☐ Type 2 ☐

Medication taken Insulin ☐ Oral ☐ Both ☐

Last HgbA1C ______________

Who manages your diabetes? ______________________________

High Blood Pressure

High blood pressure? Yes ☐ No ☐

If yes, year diagnosed? _

Monitored at home? _

Average reading? ________ / ________

Who manages BP? _

EENT

Blindness Yes ☐ No ☐ Hearing Problems Yes ☐ No ☐

Cataracts Yes ☐ No ☐ Glaucoma Yes ☐ No ☐

Patient Name:________________________________ Patient DOB: _________________

Heart

Heart Disease	Yes	☐	No ☐	AICD	Yes	☐	No	☐
Atrial Fibrillation	Yes	☐	No ☐	Valvular Disease	Yes	☐	No	☐
Pacemaker	Yes	☐	No ☐	Congestive Failure	Yes	☐	No	☐
High Cholesterol	Yes	☐	No ☐	Mitral Valve Prolapse	Yes	☐	No	☐
Irregular Heartbeat	Yes	☐	No ☐	Murmur	Yes	☐	No	☐

If yes to any, who manages your heart disease? ______________________________

Have you ever had cardiac surgery? Yes ☐ No ☐

Respiratory

COPD	Yes	☐	No ☐	Pneumonia	Yes	☐	No	☐
Chronic Bronchitis	Yes	☐	No ☐	Tuberculosis	Yes	☐	No	☐
Asthma	Yes	☐	No ☐	Sleep Apnea	Yes	☐	No	☐
Emphysema	Yes	☐	No ☐	Pulmonary Hypertension	Yes	☐	No	☐

Do you use a C-PAP? Yes ☐ No ☐

Do you wear chronic oxygen? Yes ☐ No ☐

Do you see a lung doctor? Yes ☐ No ☐

If so, who? ____

Gastrointestinal (GI)

GERD	Yes	☐	No	☐
Inflammatory Bowel Disease	Yes	☐	No	☐
Stomach/Bowel Ulcers	Yes	☐	No	☐
Irritable Bowel Syndrome	Yes	☐	No	☐

Gallbladder Disease	Yes	☐	No ☐	Gluten Intolerance	Yes	☐	No	☐
Hepatitis	Yes	☐	No ☐	Lactose Intolerance	Yes	☐	No	☐

Had a Colonoscopy? Yes ☐ No ☐ If yes, year? ________________

Had an Upper Endoscopy? Yes ☐ No ☐ If yes, year? ________________

See a stomach doctor? Yes ☐ No ☐ If so, who? ________________

Genitourinary

Kidney Stones	Yes	☐	No	☐
Polycystic Kidney Disease	Yes	☐	No	☐
Frequent Urinary Tract Infections	Yes	☐	No	☐
Solitary Kidney	Yes	☐	No	☐
Prostate problems	Yes	☐	No	☐
Do you see a urologist?	Yes	☐	No	☐

If so, who? ________________________________

Musculoskeletal

Gout Yes ☐ No ☐ Osteoporosis Yes ☐ No ☐

Osteoarthritis Yes ☐ No ☐ Scoliosis Yes ☐ No ☐

Back/Spinal Injury Yes ☐ No ☐

Neurological

Stroke Yes ☐ No ☐ Parkinson's Yes ☐ No ☐

Neuropathy Yes ☐ No ☐ Dementia Yes ☐ No ☐

Seizures Yes ☐ No ☐ Memory Issues Yes ☐ No ☐

Do you see a Neurologist? Yes ☐ No ☐ If so, who? ________________________

Psychiatric

Depression Yes ☐ No ☐ Anxiety Disorder Yes ☐ No ☐

Endocrine

Hypothyroidism Yes ☐ No ☐ Hyperthyroidism Yes ☐ No ☐

Hyperparathyroidism Yes ☐ No ☐ Adrenal Insufficiency Yes ☐ No ☐

Obesity Yes ☐ No ☐

Do you see an endocrinologist? Yes ☐ No ☐

If so, who? ____

Hematology

Cancer Yes ☐ No ☐

If yes, type?____ Year ___________________________

Treatment type ____

Sickle Cell Trait Yes ☐ No ☐ Sickle Cell Disease Yes ☐ No ☐

Blood Transfusion Yes ☐ No ☐ Thalassemia Yes ☐ No ☐

Anemia Yes ☐ No ☐ Blood Doctor? ___________________________

Autoimmune

Lupus Yes ☐ No ☐ Rheumatoid Arthritis Yes ☐ No ☐

Multiple Sclerosis Yes ☐ No ☐ Vasculitis Yes ☐ No ☐

Do you see a Rheumatologist? Yes ☐ No ☐

If so, who? ____

HIV/AIDS Yes ☐ No ☐ When diagnosed? ____________________

If so, on medication? Yes ☐ No ☐ Who manages? __________________________

Miscellaneous

Chronic Pain Yes ☐ No ☐

If yes, who manages? ____

Functional Disability Yes ☐ No ☐ Mental Disability Yes ☐ No ☐

Patient Name:________________________________ Patient DOB: ________________

Additional Medical History

Surgical History

Appendectomy	Yes	☐	No	☐	Hysterectomy	Yes	☐	No ☐
CABG	Yes	☐	No	☐	Nephrectomy	Yes	☐	No ☐
Carotid Endarterectomy	Yes	☐	No	☐	Cardiac Valve Replacement	Yes	☐	No ☐
Thyroidectomy	Yes	☐	No	☐	D&C / C-Section	Yes	☐	No ☐
Tonsillectomy	Yes	☐	No	☐	Gallbladder Removal	Yes	☐	No ☐
Cataract Surgery	Yes	☐	No	☐	Gastric Bypass	Yes	☐	No ☐
AV Fistula	Yes	☐	No	☐	Hemorrhoidectomy	Yes	☐	No ☐
AV Graft	Yes	☐	No	☐	Hernia Repair	Yes	☐	No ☐
PD Catheter	Yes	☐	No	☐	Hip Replacement	Yes	☐	No ☐
Knee Replacement	Yes	☐	No	☐	Other:			

Family History

Kidney Disease	Father	☐	Mother	☐	Sister	☐	Brother	☐
High Blood Pressure	Father	☐	Mother	☐	Sister	☐	Brother	☐
Heart Disease	Father	☐	Mother	☐	Sister	☐	Brother	☐
Diabetes	Father	☐	Mother	☐	Sister	☐	Brother	☐
Cancer	Father	☐	Mother	☐	Sister	☐	Brother	☐
Stroke	Father	☐	Mother	☐	Sister	☐	Brother	☐
Gout	Father	☐	Mother	☐	Sister	☐	Brother	☐
Autosomal Dominant Polycystic	Father	☐	Mother	☐	Sister	☐	Brother	☐
Kidney Disease	Father	☐	Mother	☐	Sister	☐	Brother	☐
Dementia	Father	☐	Mother	☐	Sister	☐	Brother	☐
Autoimmune disorder	Father		Mother		Sister		Brother	

Father Living Age: _______________ Deceased Age: _________________

Mother Living Age: _______________ Deceased Age: _________________

Patient Name:______________________________ Patient DOB: ________________

Social History

Marital Status	Married	☐	Single	☐	Separated	☐
	Widowed	☐	Divorced	☐		
Living Arrangement	Alone	☐	Spouse	☐		
	Family Member	☐	In-home Caregiver	☐		
	Assisted Living	☐	Name: ______________________________			
	Nursing Home	☐	Name:______________________________			
Occupation	Retired	☐	Previous Occupation:	________________________		
	Employed	☐	Current Occupation:	________________________		
	Student	☐	Unemployed	☐		
Functional/ Cognitive	None	☐	Memory Deficit	☐	Hearing Loss	☐
	Poor vision	☐	Blindness	☐	Limited Mobility	☐
	Transportation Challenges	☐				

Habits

		Never	Former	Current	Amount
Tobacco	Cigarettes	☐	☐	☐	_________
	Pipes	☐	☐	☐	_________
	Snuff	☐	☐	☐	_________
	Cigars	☐	☐	☐	_________
	Chew	☐	☐	☐	_________
Alcohol	< 1 Week	☐	☐	☐	
	1 per week	☐	☐	☐	
	2-3 per week	☐	☐	☐	
	1 per day	☐	☐	☐	
	> 1 per day	☐	☐	☐	

Recreational Drug Use	Never	Former	Current
Marijuana	☐	☐	☐
Heroin	☐	☐	☐
Cocaine	☐	☐	☐
Amphetamines	☐	☐	☐
Ecstasy	☐	☐	☐
Barbiturates	☐	☐	☐
LSD	☐	☐	☐
Opium	☐	☐	☐
Other	☐	☐	☐