Medical History Form

Name of Family Physician _____ **Phone** _____ **Date of Last Visit** _____

Current Kidney Problem

Why are you being referred?

How long have you had this condition?

Is there a family history of this condition?

Have you ever been treated for the following problems?

Anemia ☐
Gout ☐

Asthma/ COPD/ Emphysema ☐
Heart Disease - Congestive Heart Failure ☐

Diabetes ☐
Heart Disease - Heart Attack ☐

High Cholesterol ☐

High Blood Pressure ☐

Arthritis - Rheumatoid / Osteoarthritis ☐

Lupus ☐
Polycystic Kidney Disease (PKD) ☐
Seizure Disorder ☐
Hepatitis ☐
Other (Hospitalizations/ Injuries) ☐

Peripheral Vascular Disease ☐
Kidney Stones ☐
Stroke (TIA) ☐
HIV ☐

Renal Failure (Acute / Chronic) ☐
Thyroid Disease ☐
Prostate Disease ☐
Cancer ☐

What year were you diagnosed? Please use the following format: Anemia, 2019

Any Other Medical Conditions Not Listed Above?

Have you ever taken (check the box):

☐ Lithium ☐ Fleets Phosphosoda ☐ Gentamycin ☐ Tobramycin ☐ Cisplatinum

Have you had previous exposure to gadolinium (a contrast agent) during an MRI?

Surgical History (*cont. on next page*)

Surgical History

☐ Hysterectomy/Ovary Removal ☐ Hernia Repair ☐ Tonsillectomy ☐ Appendectomy

☐ Heart - Coronary Bypass ☐ Heart / Valve ☐ Heart - AICD / Pacemaker ☐ Heart - Angioplasty or Stent

☐ Cancer Surgery ☐ Joint Surgery ☐ Back Surgery ☐ Gall Bladder ☐ Kidney ☐ Bladder ☐ Transplant

☐ Vascular

If you checked any of the above surgeries, please use this box to disclose the year in which the surgery was performed and the surgeon who performed it. (Example: Hernia Repair, 2003, Dr. John Doe)

Other Medical History Including Immunizations

General Medical History Review

Do you have chronic difficulty with any of the following? Please indicate by checking below.

Appetite Loss ☐	**Double Vision** ☐	**Leg Pain/Swelling** ☐	**Rectal bleeding** ☐	**Joint pain** ☐
Chills ☐	**Headache** ☐	**Palpitations** ☐	**Vomiting** ☐	**Muscle aches** ☐
Fatigue ☐	**Hearing Loss** ☐	**Shortness of breath** ☐	**Vomiting blood** ☐	**Loss of consciousness** ☐
Fever ☐	**Nose Bleed/Sinusitis** ☐	**Constipation** ☐	**Blood in urine** ☐	**Numbness** ☐
Weight Gain ☐	**Ringing in ears** ☐	**Diarrhea** ☐	**Cloudy urine** ☐	**Seizures** ☐
Weight Loss ☐	**Chronic Cough** ☐	**Heartburn** ☐	**Excessively foamy urine** ☐	**Weakness in extremities** ☐
Itchy Skin ☐	**Coughing up blood** ☐	**Jaundice** ☐	**Foul smelling urine** ☐	**Anxiety** ☐
Skin Rash ☐	**Difficulty breathing** ☐	**Liver Disease** ☐	**Frequent urination** ☐	**Confusion** ☐
Blurred Vision ☐	**Wheezing** ☐	**Nausea** ☐	**Painful urination** ☐	**Depression** ☐
Dental/Mouth Problems ☐	**Chest Pain** ☐	**Painful Swallowing** ☐	**Urinating at night** ☐	**Mood changes** ☐
Cold Flashes ☐	**Excessive sweating** ☐	**Hot Flashes** ☐	**Easy bruising** ☐	**Excessive bleeding** ☐

Family History (Please list any known medical problems.)

Father

Mother

Siblings

Your Children

Social History

Do you drink alchohol?

Yes or No

If yes, how many years have you drunk alcohol?

# of drinks per day?

Do you use illegal/street drugs?

Yes or No

If yes, what kind(s) of drug and for how many years?

Do you smoke cigarettes, cigars, or a pipe?

How many did you or do you smoke per day (packs)?

How many years have you smoked?

If applicable, when did you quit smoking?

Please list any industrial exposures you may have encountered (i.e. dust, fumes, solvents, chemicals, etc.)

_____

Pharmacy Information

Pharmacy Name:

_____

Pharmacy Phone Number:

_____

List any allergies to medications you have below in the following format (Name of Drug, Type of Reaction).

Medication List - Include all medications as well as inhalers used for respiratory problems, herbal supplements, and vitamins.

Medication	Dose	Frequency	Date Started
Medication	Dose	Frequency	Date Started
Medication	Dose	Frequency	Date Started
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Do you have any other medical history you feel would be helpful in your care?

By signing below, I confirm that I have reviewed the information on this medical history form and it is accurate to the best of my knowledge. I understand that this information will be used by the doctor to help determine appropriate and healthful treatment. If there is any change in my medical status, I will inform the doctor.

Signature Of Responsible Party: **Date:**