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 ☐ Protein Spilling in the Urine? 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 ☐ Diabetic Retinopathy Yes ☐ No ☐

Year Diagnosed? _____

Medication taken Insulin ☐ Oral ☐ Both ☐

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 ☐	Cardiac Defibrillator	Yes ☐	No ☐
Atrial Fibrillation	Yes ☐	No ☐	Valvular Disease	Yes ☐	No ☐
Congestive Failure	Yes ☐	No ☐	Pacemaker	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 ☐	Gallbladder Disease	Yes ☐	No ☐
Inflammatory Bowl Disease	Yes ☐	No ☐	Hepatitis	Yes ☐	No ☐
Stomach/Bowel Ulcers	Yes ☐	No ☐	Gluten Intolerance	Yes ☐	No ☐
Irritable Bowel Syndrome	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 ☐	Solitary(One)Kidney	Yes ☐	No ☐
Polycystic Kidney Disease	Yes ☐	No ☐	Prostate Problems	Yes ☐	No ☐
Do you see a Urologist?	Yes ☐	No ☐	Frequent Urinary Tract Infections	Yes ☐	No ☐

If so, who? _____

Patient Name: _____ Patient DOB: _____

Musculoskeletal

Gout Yes☐ No☐ Osteoporosis Yes☐ No☐

Date/Year diagnosed? _____ Scoliosis Yes☐ No☐

_____

Back/Spinal Injury Yes☐ No☐ Osteoarthritis Yes☐ No☐

If Yes, do you take OTC Meds?

_____

Neurological

Stroke Yes☐ No☐ Parkinson's Yes☐ No☐

Neuropathy Yes☐ No☐ Dementia Yes☐ No☐

Siezures 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 Disease Yes☐ No☐ Anemia Yes☐ No☐

Blood Transfusion Yes☐ No☐ If yes, Year diagnosed? _____

_____

Thalassemia Yes☐ No☐ Blood Doctor? _____

Patient Name: _____ Patient DOB: _____

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☐

Additional Medical History

Surgical History

Surgery	Yes	No	Year/Age?		Yes	No	Year/Age?
Thyroidectomy				Gallbladder Removal			
Parathyroidectomy				Cataract Surgery			
Carotid Endarterectomy				Retinopathy Surgery			
CABG				Gastric Bypass			
Cardiac Valve Replacement				PD Catheter			
Hip Replacement				AV Graft (Right Left)			
Knee Replacement				AV Fistula (Right/Left)			
Joint Replacement				Nephrectomy (Right/Left)			

Other Surgery:

Patient Name: _____ Patient DOB: _____

Family History

	Father	Mother	Sister	Brother
Kidney Disease				
Polycystic Kidney Disease				
High Blood Pressure				
Diabetes				
Gout				
Heart Disease				
Cancer				
Stroke				
Dementia				
Autoimmune Disorder				

Adopted ☐

Father	Living ☐ Deceased ☐
Mother	Living ☐ Deceased ☐

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 Occupatiohn:**_____
Unemployed ☐ **Student** ☐

Functional/Cognitive:

None ☐ Poor Vision/Blindness ☐ Hearing loss ☐ Limited Mobility ☐
Memory Deficit ☐ Impairment ☐ Transportation Challenges ☐

Patient Name: _____ Patient DOB: _____

Habits

		Never	Former	Current	If Yes
Tobacco	Cigarettes	☐	☐	☐	Start?
	E Cigarette/Vape	☐	☐	☐	Quit?
	Cigars	☐	☐	☐	Packs per day?
	Pipes	☐	☐	☐	Years Smoked?
	Snuff	☐	☐	☐	
	Chew	☐	☐	☐	
		Never	Former	Current	Drinks Per week
Alcohol	Beer	☐	☐	☐	
	Wine	☐	☐	☐	
	Liquor	☐	☐	☐	
Recreational Drug Use		Never	Former	Current	Use per week
	Marijuana	☐	☐	☐	
	Heroin	☐	☐	☐	
	“Crack” Cocaine	☐	☐	☐	
	Cocaine	☐	☐	☐	
	Codeine	☐	☐	☐	
	Amphetamines	☐	☐	☐	
	MDMA (Ecstasy)	☐	☐	☐	
	Barbituates	☐	☐	☐	
	LSD	☐	☐	☐	
	Opium	☐	☐	☐	
	Oxycodone	☐	☐	☐	
	PCP	☐	☐	☐	
	Other	☐	☐	☐	

Historical Medications: Herbal Medication or NSAIDs (Non-Steroidal Anti Imflammatory Drugs)

Name	**Strength**	**Frequency**
Alieve/Advil/Ibuprofen?		
Herbal Medications?		