SIGNATURE
KIDNEY CARE

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Irving, TX. 75061

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HEALTH HISTORY QUESTIONNAIRE

Patient Name: _____ Date: _____

***Your answers on this form will help your doctor better understand your medical concerns and conditions.**

***If you are uncomfortable with any question, do not answer it.**

***If you cannot remember specific details, please approximate.**

***Add any notes you think are important.**

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Main reason for the visit: _____

Other concerns: _____

ALLERGIES AND REACTION: No Known Drug Allergies.

_____ _____

_____ _____

_____ _____

YOUR FAVORATE PHARMACY:

Name: _____

Address: _____

MEDICATIONS:

DRUG NAME	STRENGTH	FREQUENCY TAKEN

PAST MEDICAL HISTORY: Please check all that apply.

Anxiety Disorder	Diverticulitis	Kidney Disease
Arthritis	Fibromyalgia	Kidney Stones
Asthma	Gout	Leg/Foot Ulcers
Bleeding Disorder	Has Pacemaker	Liver Disease
Blood Clots (or DVT)	Heart Attack	Osteoporosis
Cancer	Heart Murmur	Polio
Coronary Artery Disease	Hiatal Hernia or Reflux Disease	Pulmonary Embolism
Claustrophobic	HIV or AIDS	Reflux or Ulcers
Diabetes - Insulin	High Cholesterol	Stroke
Diabetes - Non-Insulin	High Blood Pressure	Tuberculosis
Dialysis	Overactive Thyroid	Other

OTHER: _____

_____

PAST SURGICAL HISTORY:

SURGERY	REASON	YEAR	HOSPITAL

FAMILY HEALTH HISTORY:

RELATION	SIGNIFICANT HEALTH ISSUES
Maternal Grandmother	Blood pressure. Diabetes. Cholesterol. Heart. Kidney. Lung. Liver. Cancer.
Paternal Grandmother	Blood pressure. Diabetes. Cholesterol. Heart. Kidney. Lung. Liver. Cancer.
Maternal Grandfather	Blood pressure. Diabetes. Cholesterol. Heart. Kidney. Lung. Liver. Cancer.
Paternal Grandfather	Blood pressure. Diabetes. Cholesterol. Heart. Kidney. Lung. Liver. Cancer.
Maternal Uncles/Aunts	Blood pressure. Diabetes. Cholesterol. Heart. Kidney. Lung. Liver. Cancer.
Paternal Uncles/Aunts	Blood pressure. Diabetes. Cholesterol. Heart. Kidney. Lung. Liver. Cancer.
Father:	Blood pressure. Diabetes. Cholesterol. Heart. Kidney. Lung. Liver. Cancer.
Mother:	Blood pressure. Diabetes. Cholesterol. Heart. Kidney. Lung. Liver. Cancer.
Brothers:	Blood pressure. Diabetes. Cholesterol. Heart. Kidney. Lung. Liver. Cancer.
Sisters:	Blood pressure. Diabetes. Cholesterol. Heart. Kidney. Lung. Liver. Cancer.
Maternal Cousins:	Blood pressure. Diabetes. Cholesterol. Heart. Kidney. Lung. Liver. Cancer.
Paternal Cousins:	Blood pressure. Diabetes. Cholesterol. Heart. Kidney. Lung. Liver. Cancer.

OTHER RELATIVES: _____

_____

OTHER HEALTH ISSUES: _____

_____

SOCIAL HISTORY:

MARITAL STATUS: Married. Single. Divorced.
Separated. Widowed. Domestic Partner.

TOBACCO: **YES/NO**. How much? _____ For how long? _____

Did you ever smoke? **YES.** How much? _____
NO. When did you quit? _____

Type: Cigarettes. Chewing. Vaping. Cigars.

ALCOHOL: **YES/ NO**. How often? _____ How many drinks each time? _____

DRUGS: **YES/NO**. Recreational/street drugs? List: _____

EDUCATION: <8th grade. High School. 2 Year College.
4 Year College. Postgraduate.

OCCUPATION: _____

EXERCISE: NONE. OCCASIONAL. MODERATE. HIGH LEVEL.

CAFFEINE: NONE OCCASIONAL MODERATE HEAVY
No. of cups a day? _____

REVIEW OF SYSTEMS:

Please circle all that apply:

ALLERGIC/IMMUNOLOGIC

Frequent Sneezing

Hives

Itching

Runny Nose

Sinus Pressure

CARDIOVASCULAR

Arm Pain on Exertion

Chest Pain on Exertion

Chest Heaviness/Pressure on Exertion

Irregular Heart Beats (Palpitations)

Known Heart Murmur

Light-headed on Standing

Shortness of Breath When Lying Down

Shortness of Breath When Walking

Swelling (edema)

CONSTITUTIONAL

Exercise Intolerance

Fatigue

Fever

Weight Gain (____lbs/ time)

Weight Loss (____lbs/ time)

EYES

Red Eyes/ Dry eyes

Eye Pain

Vision Change

EARS/NOSE/MOUTH/THROAT

Bleeding Gums

Difficulty Hearing

Dizziness

Dry Mouth

Ear Pain

Frequent Infections

Frequent Nosebleeds

Hoarseness

Mouth Breathing

Mouth Ulcers

Nose/Sinus Problems

Ringing in Ears

ENDOCRINE

Fatigue

Increased

Thirst/Hunger/

Excess Urination

GASTROINTESTINAL

Abdominal Pain

Black or Tarry Stool

Blood in Stool

Change in Appetite

Frequent Indigestion

Hemorrhoids

Trouble Swallowing

Vomiting / Vomiting blood

GENITOURINARY

Blood in Urine

Difficulty Urinating

Incomplete Emptying

Increased Urinary Frequency

Urinary Loss of Control

HEMATOLOGIC/LYMPH

Easy Bruising/Bleeding

Swollen Glands

SKIN

Changes in Moles

Dry Skin

Eczema

Growth/Lesions

Itching

Jaundice (Yellow Skin/Eyes)

Rash

NEUROLOGICAL

Dizziness

Fainting

Headaches

Migraines

Weakness

Numbness

Restless Legs

Seizures

Balance issues

MUSCULOSKELETAL

Back Pain

Joint Pain/ Inflammation

Muscle Aches

Muscle Cramps

Muscle Weakness

MOOD/BEHAVIOR

Alcohol Overuse

Anxiety/Stress

Depression

Do Not Feel Safe in Relationship

Mania

Sleep Problems

Memory Loss

Weakness

RESPIRATORY

Cough

Coughing Up Blood

Shortness of Breath

Sleep Apnea

Snoring

Wheezing

OTHER:

_____

_____

_____

(WOMEN ONLY) OBSETRIC AND GYNECOLOGICAL HISTORY

Last PAP Smear Date_____ Normal Abnormal

Last Mammogram Date _____ Normal Abnormal

Age of first menstrual period: _____

Date of last menstrual period or age of menopause: _____

Number of pregnancies: _____ Births: _____

Miscarriages number: _____ Abortions: _____

Cesarean sections If YES, number: _____

Please circle all that apply:

Bleeding between periods

Heavy periods

Extreme menstrual pain

Vaginal itching, burning, or discharge.

Wake in the night to go to the bathroom.

Hot flashes

Breast lump or nipple discharge

Painful intercourse

Sexually active? YES NO

Current sexual partner is Female Male

Do you use condoms Yes No

Other Birth control method used: _____