WAKE NEPHROLOGY ASSOCIATES
HEALTH HISTORY
CONFIDENTIAL

PATIENT NAME: _____ DATE: _____

DATE OF BIRTH: _____ DATE OF LAST PHYSICAL EXAM: _____

WHAT IS THE REASON FOR YOUR VISIT? _____

PLEASE √ IF YOU HAVE EVERY HAD ANY OF THE FOLLOWING. USE THE _____ SPACE TO PROVIDE DETAILS AND/OR YEAR OF ONSET

KIDNEY DISEASE

□ CKD: □ Stage 1 □ Stage 2 □ Stage 3 □ Stage 4 □ Stage 5 □ Unknown

□ Transplant: Year: _____

Type: □ Cadaveric □ Living Related □ Living Unrelated

□ Dialysis: Year: _____ Type: □ Hemodialysis □ Peritoneal Dialysis

□ Polycystic kidney disease

□ Acute kidney injury Details: _____

□ Glomerulonephritis

DIABETES

□ Diabetes Type 1
□ Diabetes Type 2
□ Diabetes Type Unknown

HIGH BLOOD PRESSURE

□ Essential
□ Renovascular
□ White Coat
□ Conn's Syndrome

ISCHEMIC HEART DISEASE

□ Heart Attack Yr:_____
□ Angina
□ Angioplasty Yr:_____
□ Coronary Stent Yr: _____
□ CABG Yr:_____

□ **STROKE** Yr:_____

□ **GOUT**

CANCER

□ Lung _____ □ Lymphoma _____
□ Breast _____ □ Kidney _____
□ Prostate _____ □ Thyroid _____
□ Colon _____ □ Leukemia _____
□ Melanoma _____ □ Endometrial _____
□ Bladder _____ □ Pancreatic _____
□ Other: _____

ENT

□ Blindness
□ Cataracts
□ Hearing Problems
□ Glaucoma

CARDIOVASCULAR

□ Atrial fibrillator
□ Pacemaker
□ AICD
□ Valvular heart disease
□ Congestive heart failure
□ Mitral valve prolapse

PATIENT NAME: _____ DATE OF BIRTH: _____

RESPIRATORY

□ COPD
□ Chronic bronchitis
□ Asthma
□ Emphysema
□ Pneumonia
□ Tuberculosis
□ Sleep apnea

HEMATOLOGY

□ Anemia
□ Sickle cell disease
□ Sickle cell trait
□ Blood transfusion
□ Thalassemia

GASTROINTESTINAL

□ GERD (Gastric reflux)
□ Stomach/Bowel ulcers
□ Gall bladder disease
□ Hepatitis
□ Inflammatory bowel disease
□ Irritable bowel syndrome
□ Gluten intolerance
□ Lactose intolerance

IMMUNO/ALLERGY

□ HIV
□ AIDS
□ Rheumatoid arthritis
□ Lupus

GENITOURINARY

□ Enlarged prostate
□ Kidney stones
□ Frequent UTIs

OB HISTORY

□ Preeclampsia
□ Pregnancy induced hypertension
□ Gestational diabetes
□ History of complicated pregnancy

MUSCULOSKELETAL

□ Osteoarthritis
□ Osteoporosis

NEUROLOGIC

□ Multiple sclerosis
□ Seizures
□ Parkinson's
□ Dementia

PSYCHIATRIC

□ Depression
□ Anxiety disorder

ENDOCRINE

□ Hypothyroidism
□ Hyperthyroidism
□ Adrenal insufficiency

SURGERY HISTORY

□ Appendectomy Year: _____
□ CABG Year: _____
□ Carotid endarterectomy Year: _____
□ Cataract surgery Year: _____
□ D & C Year: _____
□ Gall bladder removal Year: _____
□ Gastric bypass Year: _____
□ Hemorrhoidectomy Year: _____
□ Hernia repair Year: _____
□ Hip replacement Year: _____
□ Left □ Right □ Bilateral
□ Knee replacement Year: _____
□ Left □ Right □ Bilateral
□ Hysterectomy Year: _____
□ Prostatectomy Year: _____
□ Nephrectomy Year: _____
□ Renal transplant Year: _____
□ Thyroidectomy Year: _____
□ Tonsillectomy Year: _____
□ Valve replacement Year: _____
□ AV fistula Year: _____
□ AV graft Year: _____
□ PD catheter Year: _____
□ Other:

PATIENT NAME: _____ DATE OF BIRTH: _____

FAMILY HISTORY

DO THE FOLLOWING FAMILY MEMBERS HAVE ANY OF THE FOLLOWING MEDICAL CONDITIONS?

KIDNEY DISEASE	□ Father	□ Mother	□ Sibling	□ Child
DIABETES	□ Father	□ Mother	□ Sibling	□ Child
HIGH BLOOD PRESSURE	□ Father	□ Mother	□ Sibling	□ Child
ISCHEMIC HEART DISEASE	□ Father	□ Mother	□ Sibling	□ Child
CANCER	□ Father	□ Mother	□ Sibling	□ Child
STROKE	□ Father	□ Mother	□ Sibling	□ Child
GOUT	□ Father	□ Mother	□ Sibling	□ Child
ADULT POLYCYSTIC KIDNEY DISEASE	□ Father	□ Mother	□ Sibling	□ Child
DEMENTIA	□ Father	□ Mother	□ Sibling	□ Child

FAMILY HISTORY - STATUS

Father: □ Living

□ Deceased Age at death: _____ Cause of Death: _____

□ Unknown

Mother: □ Living

□ Deceased Age at death: _____ Cause of Death: _____

□ Unknown

Other Family History Not Listed Above:

_____

_____

_____

_____

PATIENT NAME: _____ DATE OF BIRTH: _____

SOCIAL HISTORY

CURRENT MARITAL STATUS

□ Married □ Separated □ Single □ Widowed □ Divorced

LIVING ARRANAGEMENT

□ Alone □ Spouse □ Significant Other
□ Family member □ In home caregiver □ Assisted living facility

OCCUPATION

□ Retired □ Employed: □ Full Time □ Part Time
□ Unemployed Current Occupation: _____
□ Student

FUNCTIONAL/COGNITIVE

□ No impairment □ Memory deficit
□ Hearing loss □ Poor vision or blindness
□ Limited mobility □ Transportation challenges

SOCIAL HISTORY - HABITS

TOBACCO USE □ Current or Former User □ Never Used □ Unknown

□ Cigarettes □ Chewing tobacco □ Pipes □ Snuff □ Cigars

If a former user, what year did you quit? _____

If a current or former smoker, how often do/did you smoke? □ Every day □ Some days □ Unknown

How many packs per day do/did you smoke? _____

How many total years have you used cigarettes? _____

ALCOHOL USE □ Current or Former User □ Never Used

□ Occasional alcohol □ 1-2 per day □ 3 or more per day

If a former user, what year did you quit? _____

RECREATIONAL DRUG USE □ Current User □ Former User: Year Quit _____ □ Never used

□ Marijuana □ Heroin □ Cocaine
□ Amphetamines □ Ecstasy □ Barbiturates
□ LSD □ Opium □ Other _____

Other Social History Not Listed Above: _____

PATIENT NAME: _____ DATE OF BIRTH: _____

REVIEW OF SYSTEMS

CONSTITUTIONAL

□ Fever
□ Weight gain
□ Weight loss
□ Fatigue
□ Chills
□ Weakness

HEENT

□ Vision impaired
□ Eye pain
□ Redness
□ Color blindness
□ Double vision
□ Hearing loss
□ Ear pain
□ Sinus problems
□ Sore throat
□ Nose bleeds
□ Headache
□ Hoarseness
□ Tinnitus
□ Vertigo

RESPIRATORY

□ Shortness of breath
□ Shortness of breath at rest
□ Shortness of breath with activity
□ Pain with breathing
□ Cough
□ Wheezing
□ Blood in sputum
□ Night sweats

CARDIOVASCULAR

□ Chest pain
□ Palpitations
□ Claudication
□ Orthopnea
□ Edema
□ PND

GASTROINTESTINAL

□ Abdominal pain
□ Nausea
□ Diarrhea
□ Heartburn
□ Vomiting
□ Constipation
□ Anorexia
□ Trouble swallowing
□ Indigestion

GENITOURINARY

□ Urinary urgency
□ Urinary burning or pain
□ Blood in urine
□ Urinary frequency
□ Urinary hesitancy
□ Foamy urine
□ Incontinence
□ Nocturia

MUSCULOSKELETAL

□ Back pain
□ Neck pain
□ Joint pain
□ Muscle pain
□ Arm weakness
□ Leg weakness

SKIN

□ Rash
□ Itching
□ Scaling
□ Dryness
□ Color change

NEUROLOGICAL

□ Numbness
□ Tremors
□ Seizures
□ Tingling
□ Fainting

PSYCHIATRIC

□ Depression
□ Insomnia
□ Anxiety

ENDOCRINE

□ Heat intolerance
□ Cold interolance
□ Excessive thirst
□ Excessive urination

HEMATOLOGY

□ Bleeding gums
□ Easy bruising

IMMUNO/ALLERGY

□ Seasonal allergies
□ Hives