North Texas Nephrology Associates

Health History Questionnaire

Patient Name: ______________________

Date: ____________ Time: _________

This document will become part of your medical record and all questions and answers will remain strictly confidential. Please Read Carefully and Complete ALL SIX Sections.

Section #1 – Background Information

Please fill in the following contact information so that we may better communicate with your other physicians and pharmacists. This helps us to provide better service to you and your other providers.

Primary Care Provider: ______________________ Office Phone #: ______________________

Referring Provider (if different): ______________________ Office Phone #: ______________________

Pharmacy: ______________________ Phone #: ______________________

We sometimes need to call you to review labs/medications and make other follow-up between visits. Please note your current contact information. Circle the preferred number.

Cell Phone #: ______________________ Home Phone #: ______________________

Section #2 – Medications

Please list all ALLERGIES to medications (write NONE if no history of allergic reactions).

Drug	Reaction

Please list all MEDICATIONS that you are currently taking. Include all of your prescription medicines, over-the-counter medicines, inhalers, herbal medicines, vitamins, and injections.

Medication	Dose	Times Per Day

Section #3 – Personal Medical History

Please indicate if you have had any of the following MEDICAL PROBLEMS (with approximate date of illness or diagnosis).

Condition			Condition		
High Blood Pressure	❑ no	❑ yes	BPH (prostate enlargement)	❑ no	❑ yes
Coronary Artery Disease (or heart attack)	❑ no	❑ yes	Lupus	❑ no	❑ yes
Congestive Heart Failure	❑ no	❑ yes	Gout	❑ no	❑ yes
Arrhythmia	❑ no	❑ yes	Arthritis	❑ no	❑ yes
Circulation Problems	❑ no	❑ yes	Stroke (or TIA)	❑ no	❑ yes
COPD/Emphysema	❑ no	❑ yes	Depression	❑ no	❑ yes
Asthma	❑ no	❑ yes	Anxiety	❑ no	❑ yes
Sleep Apnea	❑ no	❑ yes	Diabetes	❑ no	❑ yes
Reflux / GERD	❑ no	❑ yes	High Cholesterol	❑ no	❑ yes
Stomach Ulcers	❑ no	❑ yes	Thyroid Disease	❑ no	❑ yes
Liver Disease	❑ no	❑ yes	Cancer	❑ no	❑ yes
Kidney Stones	❑ no	❑ yes	Bleeding Disorder	❑ no	❑ yes
Bladder or Kidney Infections	❑ no	❑ yes	HIV	❑ no	❑ yes
Polycystic Kidney Disease	❑ no	❑ yes	Hepatitis B or C	❑ no	❑ yes

Please list any other MEDICAL PROBLEMS that other doctors have diagnosed:

Medical Problem	Year

Please list any SURGERIES, with the approximate date and hospital (if known):

Surgery	Hospital	Year

Please list any other HOSPITALIZATIONS, with the approximate date and reason:

Reason for Hospitalization	Hospital	Year

Please check the appropriate boxes for IMMUNIZATIONS received. Indicate the date of your most recent immunizations.

❑ Pneumonia ______________ ❑ Hepatitis A ______________ ❑ MMR ________________ ❑ Chicken Pox __________

❑ Influenza ________________ ❑ Hepatitis B ______________ ❑ Tetanus ______________ ❑ Other ________________

Section #4 – Social History and Health Habits

Please check all appropriate boxes and fill in details where necessary.

Socioeconomic

Years of education/highest degree: ____________________

Occupation: ______________________________________

Employer: ______________________________________

Marital Status:

- ❑ Single
- ❑ Partner/Married
- ❑ Divorced/Separated
- ❑ Widowed

Number of children: __________

Who lives at home with you? _________________________

Exercise

- ❑ Sedentary (none)
- ❑ Mild exercise (i.e., climbing stairs, walk 3 blocks, golf)
- ❑ Occasional vigorous exercise (≤3x/week for 30 minutes)
- ❑ Regular vigorous exercise (≥4x/week for 30 minutes)

Diet/Nutrition

Are you currently dieting? .... ❑ No ❑ Yes

Do you limit the intake of salt/sodium? .... ❑ No ❑ Yes

Have you ever seen a nutritionist? .... ❑ No ❑ Yes

Safety Issues

Do you live alone? .... ❑ No ❑ Yes

Do you have frequent falls? .... ❑ No ❑ Yes

Do you have vision problems? .... ❑ No ❑ Yes

Do you have hearing problems? .... ❑ No ❑ Yes

Tobacco Use

- ❑ Never
- ❑ Quit; date: __________
- ❑ Current Use
  - ❑ Cigarettes: __________ packs/day:
  - ❑ Pipe: __________ /day
  - ❑ Chew: __________ /day
  - ❑ Cigar: __________ /day

Are you interested in quitting? .... ❑ No ❑ Yes

Alcohol Intake

- ❑ Never
- ❑ Quit; date: __________
- ❑ Current Use: __________ drinks/week:

Is alcohol use a concern for you or others? .. ❑ No ❑ Yes

Drugs

Have you every used recreational drugs? .... ❑ No ❑ Yes

Currently? .... ❑ No ❑ Yes

Have you ever used needles to inject drugs? ... ❑ No ❑ Yes

Caffeine

- ❑ None
- ❑ Coffee: __________ cups/day
- ❑ Tea: __________ cups/day
- ❑ Cola: __________ drinks/day

Section #5 – Family Health History

Please check the appropriate boxes concerning the health of your family members. Circle if deceased and please enter the approximate age (current or at time of death).

Relative	Mother	Father	Brothers	Sisters	Children	maternal Grandparents	paternal Grandparents	Other
Age(s)	______	______	______	______	______	______	______	______
Kidney Disease	❑	❑	❑	❑	❑	❑	❑	❑
Polycystic Kidneys	❑	❑	❑	❑	❑	❑	❑	❑
Anemia	❑	❑	❑	❑	❑	❑	❑	❑
Heart attack	❑	❑	❑	❑	❑	❑	❑	❑
Stroke	❑	❑	❑	❑	❑	❑	❑	❑
High blood pressure	❑	❑	❑	❑	❑	❑	❑	❑
Diabetes	❑	❑	❑	❑	❑	❑	❑	❑
Cancer	❑	❑	❑	❑	❑	❑	❑	❑
Bleeding Problem	❑	❑	❑	❑	❑	❑	❑	❑

Please list any other illnesses that run in the family: ____

Section #6 – Review of Symptoms

Please review the following symptoms and check the appropriate boxes for any current problems. At the bottom, note any other significant symptoms not on this list.

General, Constitutional

- Good general health ❑ no ❑ yes
- Weight change ❑ no ❑ yes
- Fevers, chills, or sweats ❑ no ❑ yes
- Fatigue ❑ no ❑ yes

Eyes and Vision

- Change in vision ❑ no ❑ yes
- Wear glasses or contact lenses ❑ no ❑ yes

Ears, Nose, Throat

- Hearing troubles ❑ no ❑ yes
- Ringing in the ears ❑ no ❑ yes
- Sinus problems ❑ no ❑ yes
- Nose bleeds ❑ no ❑ yes
- Sore throat ❑ no ❑ yes
- Bad breath or taste ❑ no ❑ yes

Heart and Cardiovascular

- Chest pain ❑ no ❑ yes
- Palpitations or heart racing ❑ no ❑ yes
- Leg pain with exercise ❑ no ❑ yes
- Swelling of feet, ankles, hands ❑ no ❑ yes

Respiratory

- Shortness of breath ❑ no ❑ yes
- Frequent coughing ❑ no ❑ yes
- Coughing up blood ❑ no ❑ yes
- Wheezing ❑ no ❑ yes

Gastrointestinal

- Loss of appetite ❑ no ❑ yes
- Abdominal pain ❑ no ❑ yes
- Nausea and/or vomiting ❑ no ❑ yes
- Diarrhea ❑ no ❑ yes
- Constipation ❑ no ❑ yes
- Blood in stools ❑ no ❑ yes
- Black/tarry stools ❑ no ❑ yes

Genitourinary

- Burning or painful urination ❑ no ❑ yes
- Frequent urination ❑ no ❑ yes
- Blood in urine ❑ no ❑ yes
- Incontinence or dribbling ❑ no ❑ yes

Musculoskeletal

- Joint pain ❑ no ❑ yes
- Joint stiffness or swelling ❑ no ❑ yes
- Back pain ❑ no ❑ yes
- Cold extremities ❑ no ❑ yes

Skin

- Rash or itching ❑ no ❑ yes
- Change in skin color ❑ no ❑ yes
- Change in hair or nails ❑ no ❑ yes

Neurological

- Frequent headaches ❑ no ❑ yes
- Light-headed or dizzy ❑ no ❑ yes
- Seizures ❑ no ❑ yes
- Numbness or tingling ❑ no ❑ yes
- Stroke ❑ no ❑ yes

Psychiatric

- Memory loss or confusion ❑ no ❑ yes
- Nervousness or anxiety ❑ no ❑ yes
- Depression ❑ no ❑ yes
- Sleep problems ❑ no ❑ yes

Endocrine

- Heat or cold intolerance ❑ no ❑ yes
- Excessive thirst or urination ❑ no ❑ yes

Hematologic / Lymphatic

- Slow to heal after cuts ❑ no ❑ yes
- Easily bruise or bleed ❑ no ❑ yes
- Transfusion ❑ no ❑ yes

Other Complaints or Issues:

Physician Review

The information above has been recorded by the patient/family +/- the assistance of office staff. I have thoroughly reviewed all information with further questioning and clarification as necessary.

Physician Signature ______________________________ Date ______________ Time ______________