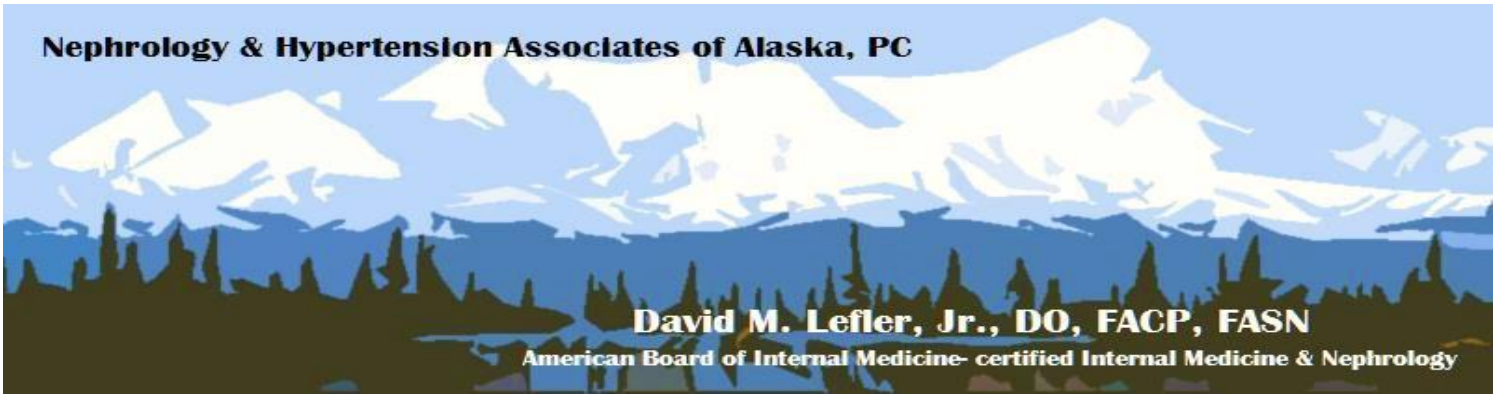

Health History Form

NAME: _____ DOB:_____ DATE:_____

What brings you to our office today:_____

CURRENT PROBLEMS (Please check all that apply)		
General ☐ Fever ☐ Chills ☐ Weight Loss/ Weight Gain ☐ Decreased Energy ☐ Loss of Appetite	**Cardiovascular** ☐ Chest Pain/ Pressure ☐ Heart Palpitations/ Arrhythmia ☐ Swelling in legs ☐ Pacemaker ☐ Recent stroke	**Endocrine/ Metabolic** ☐ Excessive Thirst ☐ Type ___ Diabetes ☐ Hair loss ☐ Heat/ Cold Intolerance ☐ Thyroid disease
Eyes ☐ Visual Disturbances ☐ Dry eyes ☐ Glaucoma ☐ Diabetes Retinopathy ☐ Macular Degeneration	**Gastrointestinal** ☐ Diarrhea ☐ Constipation ☐ Reflux/ Heartburn ☐ Bloody Stools/Vomiting Blood ☐ Colon Cancer	**Renal** ☐ High Blood Pressure ☐ Decrease in urination ☐ Kidney Transplant ☐ Electrolyte disturbances
Ears, Nose, Throat ☐ Sore Throat ☐ Sinus Pain/Pressure/Problems ☐ Swollen Glands ☐ Hearing loss	**Respiratory** ☐ Shortness of Breath ☐ Wheezing ☐ Asthma ☐ Emphysema / COPD	**Genitourinary** ☐ Pain on urination ☐ Difficulty with urination ☐ Prostate Cancer ☐ Cervical/Uterine Cancer
Hematologic ☐ Easy bruising ☐ Easy bleeding ☐ Sickle Cell Disease or Trait	**Musculoskeletal** ☐ Joint pain ☐ Back pain ☐ Muscle weakness or cramps	**Emotional** ☐ Depression ☐ Anxiety ☐ Difficulty sleeping
Health Problems not listed above:		

Allergies (Medications, Latex, Food)	Reaction

Anchorage, AK Fairbanks, AK Juneau, AK
Phone: (907)770-0412 Fax: (844) 772-0725
Website: www.nhakidney.com

MEDICAL HISTORY (CHECK ALL THAT APPLY)		
Personal History	Family History	Family Member(s) Affected
☐ Diabetes: Type _____	☐ Diabetes: Type _____	_____
☐ Heart Disease: _____	☐ Heart Disease: _____	_____
☐ Arrhythmia: _____	☐ Arrhythmia: _____	_____
☐ Stroke	☐ Stroke	_____
☐ High Cholesterol	☐ High Cholesterol	_____
☐ Hypertension/ High Blood Pressure	☐ Hypertension/ High Blood Pressure	_____
☐ Kidney Disease	☐ Kidney Disease	_____
☐ Transplant: Type _____	☐ Transplant: Type _____	_____
☐ Macular Degeneration	☐ Macular Degeneration	_____
☐ Asthma	☐ Asthma _____	
☐ COPD/ Emphysema	☐ COPD/ Emphysema _____	
☐ GERD/ Reflux disease	☐ GERD/ Reflux disease _____	
☐ Prostate disease	☐ Prostate disease _____	
☐ Arthritis	☐ Arthritis _____	
☐ Osteoporosis	☐ Osteoporosis _____	
☐ Thyroid Disease	☐ Thyroid Disease _____	
☐ Depression	☐ Depression _____	
☐ Mental Illness: Type _____	☐ Mental Illness: Type _____ _____	
☐ Hematologic Disease: _____	☐ Hematologic Disease: _____ _____	
☐ Cancer: Type _____	☐ Cancer: Type _____ _____	

MEDICATIONS (prescription, over the counter, vitamins, herbal)			
Drug	*Dosage*	*Frequency/ How Often*	*Reason(s)*

Nephrology & Hypertension Associates of Alaska, PC

David M. Lefler, Jr., DO, FACP, FASN

American Board of Internal Medicine- certified Internal Medicine & Nephrology

HOSPITALIZATIONS/ SURGERIES		
Date(s)	Reason/ Surgical Procedure	

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