



**Memphis 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**

- |   |  |
|---|--|
| <input type="checkbox"/> Lung _____     | <input type="checkbox"/> Lymphoma _____    |
| <input type="checkbox"/> Breast _____   | <input type="checkbox"/> Kidney _____      |
| <input type="checkbox"/> Prostate _____ | <input type="checkbox"/> Thyroid _____     |
| <input type="checkbox"/> Colon _____    | <input type="checkbox"/> Leukemia _____    |
| <input type="checkbox"/> Melanoma _____ | <input type="checkbox"/> Endometrial _____ |
| <input type="checkbox"/> Bladder _____  | <input type="checkbox"/> Pancreatic _____  |
| <input type="checkbox"/> Other: _____   |  |

**ENT**

- Blindness
- Cataracts
- Hearing Problems
- Glaucoma

**CARDIOVASCULAR**

- |   |   |
|---|---|
| <input type="checkbox"/> Atrial fibrillator | <input type="checkbox"/> Valvular heart disease   |
| <input type="checkbox"/> Pacemaker          | <input type="checkbox"/> Congestive heart failure |
| <input type="checkbox"/> AICD               | <input type="checkbox"/> Mitral valve prolapse    |

PATIENT NAME: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

**RESPIRATORY**

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

**GASTROINTESTINAL**

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

**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

**HEMATOLOGY**

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

**IMMUNO/ALLERGY**

- HIV
- AIDS
- Rheumatoid arthritis
- Lupus

**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?

<b>KIDNEY DISEASE</b>	<input type="checkbox"/> Father	<input type="checkbox"/> Mother	<input type="checkbox"/> Sibling	<input type="checkbox"/> Child
<b>DIABETES</b>	<input type="checkbox"/> Father	<input type="checkbox"/> Mother	<input type="checkbox"/> Sibling	<input type="checkbox"/> Child
<b>HIGH BLOOD PRESSURE</b>	<input type="checkbox"/> Father	<input type="checkbox"/> Mother	<input type="checkbox"/> Sibling	<input type="checkbox"/> Child
<b>ISCHEMIC HEART DISEASE</b>	<input type="checkbox"/> Father	<input type="checkbox"/> Mother	<input type="checkbox"/> Sibling	<input type="checkbox"/> Child
<b>CANCER</b>	<input type="checkbox"/> Father	<input type="checkbox"/> Mother	<input type="checkbox"/> Sibling	<input type="checkbox"/> Child
<b>STROKE</b>	<input type="checkbox"/> Father	<input type="checkbox"/> Mother	<input type="checkbox"/> Sibling	<input type="checkbox"/> Child
<b>GOUT</b>	<input type="checkbox"/> Father	<input type="checkbox"/> Mother	<input type="checkbox"/> Sibling	<input type="checkbox"/> Child
<b>ADULT POLYCYSTIC KIDNEY DISEASE</b>	<input type="checkbox"/> Father	<input type="checkbox"/> Mother	<input type="checkbox"/> Sibling	<input type="checkbox"/> Child
<b>DEMENTIA</b>	<input type="checkbox"/> Father	<input type="checkbox"/> Mother	<input type="checkbox"/> Sibling	<input type="checkbox"/> 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:

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PATIENT NAME: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

### SOCIAL HISTORY

#### CURRENT MARITAL STATUS

- Married       Separated       Single       Widowed       Divorced

#### LIVING ARRANGEMENT

- 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: \_\_\_\_\_

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## 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

- Joint 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 intolerance
- Excessive thirst
- Excessive urination

### HEMATOLOGY

- Bleeding gums
- Easy bruising

### IMMUNO/ALLERGY

- Seasonal allergies
- Hives