Nephrology & Hypertension Associates of Alaska, PC

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American Board of Internal Medicine- certified Internal Medicine & Nephrology

Health History Form

NAME: ____ DOB:_____________________ DATE:______________

What brings you to our office today:____

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

Allergies (Medications, Latex, Food)	Reaction

Office Location:
3300 Providence Drive, Suite B201—B Tower
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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)*

HOSPITALIZATIONS/ SURGERIES		
Date(s)	Reason/ Surgical Procedure	