NORTHWEST LOUISIANA NEPHROLOGY
PATIENT HISTORY FORM

NAME____ **AGE**________________

Did another physician refer you to this office? _______ Yes _______ No
Referring Physician:____
Primary Care Physician:____
What other physicians do you see regularly? ____
____
____

Reason for today's visit:____

PAST MEDICAL HISTORY
Please check if you have or have had any of the following conditions:

EYES:
___ Cataracts
___ Glaucoma
___ Other______________

RESPIRATORY:
___ Asthma
___ Tuberculosis
___ Bronchitis/Emphysema
___ Other______________

CARDIOVASCULAR:
___ Heart Attack
___ High Blood Pressure
___ Rheumatic Fever
___ Congestive Heart Failure
___ Other______________

RENAL/GENITOURINARY:
___ Kidney Failure
___ Urinary Tract Infections
___ Kidney Stones
___ Other______________

MUSCULOSKELETAL:
___ Arthritis
___ Back Problems
___ Other_____________

GASTROINTESTINAL:
___ Ulcer Disease
___ Ulcerative Colitis
___ Crohn's Disease
___ Other______________

Date of last colonoscopy:
____

HEPATIC (Liver):
___ Cirrhosis
___ Hepatitis
___ Other______________

DERMATOLOGIC (Skin):
___ Psoriasis
___ Skin Cancer
___ Other______________

CENTRAL NERVOUS SYSTEM:
___ Epilepsy/Seizures
___ Parkinson's Disease
___ Multiple Sclerosis
___ Stroke
___ Spinal Injury
___ Other______________

ENDOCRINE:
___ Diabetes
___ Gout
___ Thyroid Disease
___ Other________________

PSYCHIATRIC:
___ Anxiety/Depression
___ Mental Illness
___ Other________________

BLOOD/LYMPH:
___ Bleeding Disorder
___ Anemia
___ Sickle Cell Disease
___ Other________________

OTHER DISEASE:
___ IV Drug Use (past/present)
___ HIV/AIDS
___ Alcoholism
___ Cancer
___ Other________________

PAST MEDICAL HISTORY:

Please list any procedures/surgeries you have had.

PROCEDURE/SURGERY	DATE
______________________________	______________
______________________________	______________
______________________________	______________
______________________________	______________
______________________________	______________

OB/GYN HISTORY (Females Only):

Date of last menstrual period:__________________

Number of pregnancies:_______ Number of Deliveries:_______ Number of C-sections:______

Date of last pap smear: __________________ Date of last mammogram: ____________________________

ALLERGIES:

Are you allergic to any medications? _______ Yes _______ No

If yes, please list and describe your reaction to the medication (hives, rash, etc.):

____

____

MEDICATIONS:

Please list any medications you are presently taking (prescription and over-the-counter):

DRUG	DOSAGE	TIMES PER DAY
________________	__________	________________
________________	__________	________________
________________	__________	________________
________________	__________	________________
________________	__________	________________
________________	__________	________________
________________	__________	________________
________________	__________	________________
________________	__________	________________

SOCIAL HISTORY:

Are you currently employed? _______ Yes _______ No

Present or most recent occupation: ____

Marital Status: _______ Married _______ Single _______ Divorced _______ Widowed

Have you ever smoked? _______ Yes _______ No

If yes, how many packs per day? ________________ How many years? __________

Do you drink alcohol? _______ Yes _______ No How many drinks per week? ______________

What are your hobbies? ____

Are you presently taking any herbal supplements? _______ Yes _______ No

FAMILY HISTORY:

Has any family members had any of the following conditions?

	Yes	No	Relation
➢ Bladder Cancer	______	______	______________________________
➢ Kidney Cancer	______	______	______________________________
➢ Prostate Cancer	______	______	______________________________
➢ Other Cancer	______	______	______________________________
➢ Kidney Stones	______	______	______________________________
➢ Heart Disease	______	______	______________________________
➢ High Blood Pressure	______	______	______________________________
➢ Diabetes	______	______	______________________________
➢ Tuberculosis	______	______	______________________________
➢ Other____________________	______	______	______________________________

REVIEW OF SYSTEMS:

Please check any of the following that you have recently experienced:

General

___ Fever/chills
___ Weight loss
___ Weight gain
___ Night sweats
___ Fatigue

Eyes

___ Double/blurred vision
___ Pain/redness
___ Glaucoma
___Diabetic changes

ENT

___ Earache
___ Hearing loss
___ Ringing in ears
___ Congestion/sinus
___ Dry mouth
___ Sore throat
___ Hoarseness

Allergies

___ Sneezing
___ Watery/itching eyes
___ Nasal discharge

Cardiovascular

___ Chest pain
___ Palpitations
____ Shortness of breath
___ Swelling

Respiratory

___ Cough
___ Sputum/blood
___ Wheezing
___ Asthma
___ Bronchitis/pneumonia

Gastrointestinal

___ Heartburn
___ Nausea/vomiting
___ Constipation
___ Diarrhea
___ Abdominal pain
___ Blood in stool
___ Liver disease/hepatitis

Endocrine

___ Heat/Cold intolerance
___ Excessive sweating
___ Excessive thirst

Genitourinary

___ Urinary frequency
___ Urinary urgency
___ Pain w/urination
___ Blood in urine
___ Excessive urination
___ Change in stream
___ Urinating at night
_____ # of times
___ Urinary incontinence
___ Bladder infection
___ Kidney infection
___ Incomplete bladder emptying
___ Prostate problems
___ Kidney stones
___ Stent

OB/GYN (Females)

___ Breast tenderness/lumps
___ Nipple discharge
___ Abnormal vaginal bleeding

Musculoskeletal

___ Back pain
___ Joint pain/stiffness
___ Gout

Skin

___ Rash/lesions
___ Itching/dry skin
___ Color change

Neurologic

___Numbness/tingling
___ Headaches
___ Dizzy/fainting
___ Tremors
___ Stroke

Psychological

___ Anxiety/depression
___ Memory loss

Hematology

___ Easy bleed/bruising
___ Blood clotting problems
___ Enlarged lymph nodes