Hypertension and Kidney Specialists

Patient History Form

The following information is very important to your health. Please take the time to fully and accurately fill out this form.

Name: _____ **Date of Birth**: _____

Which physician or practice referred you to Hypertension and Kidney Specialists

_____

What is your understanding of why you are being seen? _____

Current Medical Problems (examples: diabetes, high blood pressure, high cholesterol, other medical problems for which you take medications, etc)

1)_____ 2)_____ 3)_____

4)_____ 5)_____ 6)_____

Others_____

Past Medical Problems that are no longer active (example heart attack, stroke, cancer that is in remission)

1)_____ 2)_____ 3)_____

4)_____ 5)_____ 6)_____

Others_____

Past Surgeries you have had (example appendix removed, gallbladder removed, etc)

1)_____ 2)_____ 3)_____

Others_____

Do you have a History in Your Family of:

Kidney Disease including anyone		
on dialysis or needed kidney transplant	No	Yes
Hypertension "high blood pressure"	No	Yes
Blood or protein in the urine	No	Yes
Rheumatologic condition such as	No	Yes
Lupus, Rheumatoid Arthritis	No	Yes

If yes to the above, please explain who

_____

Have you or do you:

Smoke No Yes Quit? _____

Drink Alcohol No Yes

if yes how much_____

Ever used illicit or

recreational drugs No Yes

if yes which ones_____

Drink caffeine No Yes

if yes how much_____

Are you allergic to any medications or environmental allergens (food, bees, etc):

_____

Have you ever received a Pneumonax (pneumonia vaccine)? No Yes (if yes when)_____
Did you receive influenza vaccine this year? No Yes
List All Medications (including Over the Counter and herbal medications) currently being taken or stopped in last month. **Please bring all your medication bottles with you to your appointment.**

_____
_____
_____
_____

Do you follow special diet (low salt, diabetic, etc) _____

Do You Have or Have History of

Weight Loss or Weight Gain	No	Yes	**Pain with urination**	No	Yes
If Yes how many pounds_____			**Blood in urine**	No	Yes
Fevers or Night Sweats	No	Yes	**Kidney stones**	No	Yes
Vision Problems	No	Yes	**Frequent Bladder Infection**	No	Yes
Bleeding in eye from high blood			**Are you up at night to urinate**	No	Yes
pressure or diabetes	No	Yes	**Painful Joints**	No	Yes
Diabetes in your eye(s)	No	Yes	**Numbness in hands or feet**	No	Yes
Problems with Sinuses	No	Yes	**Weakness in arms or legs**	No	Yes
Persistent Cough	No	Yes	**Bruise or bleed easily**	No	Yes
Coughing up blood	No	Yes	**Skin Rash**	No	Yes
Tuberculosis or exposure to Tb	No	Yes	**Depressed Mood**	No	Yes
Chest pain or tightness	No	Yes	**Confusion**	No	Yes
Swollen legs, feet, around eyes	No	Yes	**Excessive Thirst**	No	Yes
Irregular or rapid heart beat	No	Yes	**Loss of appetite**	No	Yes
Do you take medications for upset			**Bad taste in your mouth**	No	Yes
stomach/heartburn	No	Yes	**Have you ever been denied**		
Nausea/vomiting	No	Yes	**ability to donate blood**	No	Yes
Jaundice or Hepatitis	No	Yes			

I attest that the above information is true and correct to the best of my knowledge.

Name: _____ Date: _____

Office use only:

Reviewed by _____ Date:_____