NEPHROLOGY & HYPERTENSION MEDICAL ASSOCIATES Return 5 days prior to appointment

PATIENT NAME _____AGE ___ BIRTHDATE _____ TODAY'S DATE _____

What is your reason for today's visit? _____

REVIEW OF SYSTEMS (ROS) *Check symptoms you currently have or have had in the past year.*

GENERAL
Height _____
Usual weight _____lbs.
Date of last physical exam _____

- ▢ Chills
- ▢ Fever
- ▢ Sweats
- ▢ Loss of sleep
- ▢ Loss of weight
- ▢ Tired
- ▢ Weight gain

EYES
- ▢ Blurred vision
- ▢ Pain in eyes
- ▢ Vision Changes
- ▢ Vision – Halos

EARS, NOSE, THROAT
- ▢ Earache/drainage
- ▢ Loss of hearing
- ▢ Ringing in ears
- ▢ Nasal drainage
- ▢ Nosebleeds
- ▢ Sinus Problems
- ▢ Hoarseness
- ▢ Bleeding Gums
- ▢ Swallowing difficulty

MENTAL
- ▢ Anxiety
- ▢ Nervousness
- ▢ Depression

CARDIOVASCULAR
- ▢ Abdominal EKG
- ▢ Chest pain, tightness, pressure
- ▢ Fainting, blacking out
- ▢ High blood pressure
- ▢ Irregular heart beat
- ▢ Leg pain when walking
- ▢ Low blood pressure
- ▢ Poor circulation
- ▢ Rapid heart beat
- ▢ Swelling of ankles or feet
- ▢ Varicose veins
- ▢ Cold/numb feet or hands

GASTROINTESTINAL
- ▢ Appetite poor
- ▢ Bloating
- ▢ Bowel changes
- ▢ Constipation
- ▢ Diarrhea
- ▢ Eating habit changes
- ▢ Excessive hunger
- ▢ Gas
- ▢ Hemorrhoids
- ▢ Indigestion
- ▢ Nausea and/or vomiting
- ▢ Rectal bleeding

NEUROLOGICAL
- ▢ Convulsions, fits, seizures
- ▢ Dizziness
- ▢ Double vision
- ▢ Forgetfulness
- ▢ Headache
- ▢ Numbness

HEMATOLOGIC
- ▢ Bleeding tendency

SKIN
- ▢ Bruise easily
- ▢ Change in moles
- ▢ Change in skin color
- ▢ Scars
- ▢ Sore that won't heal

RESPIRATORY
- ▢ Chest colds (frequent)
- ▢ Persistent cough
- ▢ Coughing of blood
- ▢ Difficulty breathing
- ▢ Wheezing

GENITOURINARY
- ▢ Blood in urine

Urination:
- ▢ > twice overnight
- ▢ Painful
- ▢ Loss of control
- ▢ Dribbling urine
- ▢ Pass more water than used to
- ▢ Lose urine when cough/sneeze
- ▢ Decrease in force/function

MUSCLE/JOINT/BONE
Pain, weakness, numbness in:

▢Arms	▢Hips	▢Elbows
▢Back	▢Legs	▢Wrist
▢Feet	▢Neck	▢Ankle
▢Hands	▢Shoulder	▢Feet
	▢Knees	

- ▢Trouble walking

ALLERGIC
- ▢Hives
- ▢Rash or itching

ENDOCRINE
- ▢Excessive thirst

MEN ONLY
- ▢Breast lump
- ▢Erection difficulties
- ▢Lump in testicles
- ▢Penis discharge
- ▢Sore on penis
- ▢Enlarged prostate
- ▢Other _____

WOMEN ONLY
- ▢Abnormal Pap Smear
- ▢Bleeding between periods
- ▢Breast lump
- ▢Extreme menstrual pain
- ▢Hot flashes
- ▢Nipple discharge
- ▢Painful intercourse
- ▢Vaginal discharge
- ▢Other_____

Date of Last Pap Smear

_____

Date of Last Mammogram

_____

Are you pregnant?
▢ No ▢ Yes
Number of Children ___

PAST MEDICAL, FAMILY, AND SOCIAL HISTORY (check conditions you currently have or have had in the past)

- ▢ AIDS
- ▢ Alcoholism
- ▢ Anemia
- ▢ Anorexia
- ▢ Arthritis
- ▢ Asthma
- ▢Bladder/Kidney Infections
- ▢ Bleeding Disorders
- ▢ Breast Lump
- ▢ Bronchitis
- ▢ Cancer
- ▢ Cardiac Cath when? _____
- ▢ Cataracts
- ▢ Chemical Dependency
- ▢ Diabetes
- ▢ Emphysema
- ▢ Epilepsy
- ▢ Gallbladder Disease
- ▢ Glaucoma
- ▢ Goiter
- ▢ Gout
- ▢ Hay Fever
- ▢ Heart Attack, MI when? _____
- ▢ Heart Disease
- ▢ Hepatitis
- ▢ High Blood Pressure
- ▢ High Cholesterol
- ▢ HIV Positive
- ▢ Jaundice
- ▢ Liver Disease
- ▢ Kidney Disease
- ▢ Migraine Headaches
- ▢ Miscarriage
- ▢ Mononucleosis
- ▢ Multiple Sclerosis
- ▢ Osteoporosis
- ▢ Pacemaker
- ▢ Pneumonia
- ▢ Psychiatric Care/Problems
- ▢ Prostate Problems
- ▢ Rheumatic Fever
- ▢ Stroke
- ▢ Suicide Attempt
- ▢ Thyroid Problems
- ▢ Tuberculosis
- ▢ Ulcers
- ▢ Vaginal Infections

PERSONAL HABITS – SOCIAL HISTORY (check all that apply)

TOBACCO
- ▢ Cigarettes # per day __
- ▢ Pipe
- ▢ Cigars

when did you start smoking?
Age/years ___
when did you stop smoking?
Age/Years ___

- ▢ Illegal drugs

ALCOHOL
- ▢ Hard Liquor
  - ▢ less than 1oz/day
  - ▢ 1-3oz/day
  - ▢ Over 3 oz/day
- ▢ Beer
  - ▢ 1 bottle/day
  - ▢ 1-3 bottles/day
  - ▢ Over 3 bottles/day
- ▢ Wine
- ▢ 1 glass/day
- ▢ 1-3 glasses/day
- ▢ Over 3 glasses/day
- ▢ Coffee ___cups/day
- ▢ Other Caffeine _____
- ▢ Use of a lot of salt
- ▢ Special food restrictions _____

SLEEPING
- ▢ Difficulty falling asleep
- ▢ Continuity disturbances
- ▢ Early morning awakening
- ▢ Daytime drowsiness

EXERCISE
- ▢Routine exercise program
- ▢Exercise at least 3 times/week

EDUCATION ▢ GED ▢ Technical School ▢ Graduate School ▢ High School ▢ College

CARETAKER ▢ Self care ▢ Relative ▢ Other _____

Return 5 days prior to appointment

PRIOR HOSPITALIZATION/ILLNESSES/INJURIES		
Year	Hospital	Reasons for Hospitalization and Outcome

OCCUPATIONAL: CHECK IF YOUR WORK EXPOSES YOU TO THE FOLLOWING

	Heavy Lifting		Hazardous Substances
	Stress		Other

Occupation:_____

- ▢ Work more than 60 hours per week
- ▢ Work more than one job
- ▢ Disabled
- ▢ Retired
- ▢ Currently unemployed
- ▢ Housewife / Homemaker

Year	Serious Illness/Injuries	Outcome

Other Physicians Currently Seeing

MEDICATIONS (List all current prescription and non-prescription medications)		

ALLERGIES

FAMILY HISTORY: Fill in health information about your family. Put a Check or fill in information in those boxes applicable to you.

	Father	Mother	Brother				Sister				Spouse	Children					
Age (if Living)			1	2	3	4	1	2	3	4		1	2	3	4	5	6
Health (G) Good (B) Bad																	
Cancer																	
Tuberculosis																	
Diabetes																	
Heart Trouble																	
High Blood Pressure																	
Stroke																	
Epilepsy / Seizures																	
Kidney Disease																	
Lupus																	
Rheumatoid Arthritis																	
Asthma, Hay Fever																	
Blood Disease																	
Age of Death																	
Cause of Death																	

Signature:_____ Date: _____