Mid-Atlantic Nephrology Associates, P.A.

PERSONAL AND MEDICAL HISTORY

Your personal and medical history information is an important component of your health care. Please take the time to complete this form, and bring it with you to your first visit.

Date: _____

Name:_____ Date of Birth:_____ Age:_____

Gender: Male _____ Female _____ Marital Status: Single_____ Married_____ Divorced____

Home #_____ Cell #_____

Work #:_____ Email:_____

Emergency Contact: _____ Relationship To You: _____

Emergency Contact Numbers:_____

Referring Doctor:_____ Phone Number:_____

Reason Referred to Kidney Doctor: _____

Current Medications (Including Vitamin and Herbal Supplements and All Over-the-Counter Medications)

	Drug Name	Dose	Frequency
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			

List all allergies to medications, food, or injected radiographic agents/dyes:

_____

List any pain or arthritis medication that you take that are not listed previously such as Tylenol, Motrin, Advil, Ibuprofen, Aleve, Nuprin, Naproxen, or Aspirin:

_____

Have you seen a kidney doctor in the past? _____

If yes, when and name of doctor seen? _____

Have you ever been on dialysis? _____ If yes, when and where? _____

Have you had a kidney biopsy? _____ If yes, when and where? _____

Have you ever been hospitalized? _____ If yes, when and why? _____

Have you recently had any of the following procedures, bowel preparations, or medications?

Exam/Preparation/Medication		When
Colonoscopy	_____	_____
Fleets Phospho-soda	_____	_____
Visicol	_____	_____
Osmo Prep	_____	_____
Any Oral Sodium Phosphate Laxative	_____	_____
Angiogram	_____	_____
Cardiac Catheterization	_____	_____
Received Dye Or Contrast For X-rays Or Other Tests	_____	_____
Antibiotics	_____	_____

PLEASE CHECK ALL THAT APPLY TO YOUR MEDICAL HISTORY

MEDICAL PROBLEMS	YEAR
□ High Blood Pressure	_____
□ Congestive Heart Failure	_____
□ Heart Attack	_____
□ Chest Pain (Angina)	_____
□ Abnormal Heart Rhythm	_____
□ Other Heart Disease or Problems	_____
□ Poor Blood Flow to Feet/Hands	_____
□ Stroke/Ischemic Attacks	_____
□ Nervous System Disease	_____
□ Seizures	_____
□ Diabetes Mellitus	_____
□ Chronic Bronchitis	_____
□ Emphysema	_____
□ Asthma	_____
□ Sleep Apnea	_____
□ Pneumonia	_____
□ Peptic Ulcer Disease	_____
□ Inflammatory Bowel Disease	_____
□ Diverticulitis	_____
□ Liver Disease: Cirrhosis/Hepatitis	_____
□ Connective Tissue Disease	_____
□ Arthritis	_____
□ Cancer	_____
□ HIV/AIDS	_____
□ Psychological Illness	_____
□ High Cholesterol	_____
□ Anemia/Blood Disorder	_____
□ Kidney Stones	_____
□ Blood Transfusions	_____

PRIOR SURGERIES	YEAR
□ Aneurysm	_____
□ Appendix	_____
□ C-Section	_____
□ Colon	_____
□ Gallbladder	_____
□ Heart Bypass	_____
□ Hysterectomy	_____
□ Ovaries	_____
□ Prostate	_____
□ Tonsils	_____
□ Tubes Tied	_____
□ Ulcer	_____
□ Kidney Transplant	_____
□ Kidney Removed	_____
□ Removal of Kidney Stones	_____
□ Cataracts	_____
□ Other	
_____	

FAMILY AND SOCIAL HISTORY

Do your parents or any other family members have a history of the following medical problems?

Medical Problems	Mother	Father	Other Family Members	Relationship
High Blood Pressure	□	□	□	
Diabetes Mellitus	□	□	□	
Kidney Stones	□	□	□	
Kidney Cysts	□	□	□	
Kidney Disease	□	□	□	
Dialysis	□	□	□	
Kidney Transplant	□	□	□	
Blood In Urine	□	□	□	
Protein In Urine	□	□	□	
Deafness	□	□	□	
Coronary Artery Disease	□	□	□	
High Cholesterol	□	□	□	
Cancer	□	□	□	

If yes, what types of cancer? _____

Do you…

Smoke? _____ How much, for how long, and how often? _____

Drink Alcohol? _____ How much and how often? _____

Exercise? _____ How frequently? _____

Use Recreational/ Intravenous Drugs? _____ How much, for how long, and how often? _____

Kidney System Review: Check All That Apply

- □ Change in Amount of Urine
- □ Change in Urine Color
- □ Wake Up During Night To Urinate____Times
- □ Frequent Urination During The Day
- □ Painful Urination
- □ Incontinence (Leaking Urine)
- □ Feeling of Incomplete Bladder Emptying
- □ Decreased Urine Stream or Dribbling
- □ Blood in Urine
- □ Protein in Urine
- □ Foamy Urine
- □ Lack of Energy or Tired All the Time

REVIEW OF SYSTEMS: Check All That Apply

GENERAL: □ Fatigue □ Night Sweats □ Fever □Chills
□ Weight Gain □ Weight Loss □ Snoring
□ Excessive Daytime Sleepiness □ Difficulty Falling/Staying Asleep

SKIN: □ Changes in Color □ Excess Sweating □ Abnormal Bleeding
□ Abnormal Bruising □ Skin Eruptions □ Excessive Itching
□ Sensitivity To The Sun

LYMPH NODES: □ Swelling □ Pain □ Drainage

HEAD: □ Headache □ Head Injury

EYES: □ Decreased Vision □ Double Vision □ Spots or Flashes
□ Inflammation □ Pain □ Cataracts

EARS: □ Decreased Hearing □ Drainage or Discharge
□ Ringing □ Vertigo/Dizziness

NOSE/SINUSES: □ Bleeding □ Discharge □ Obstruction
□ Sinus Pressure

THROAT: □ Sore Throat □ Hoarseness □ Change in Voice
□ Bleeding Gums

BREASTS: □ Mass(es) □ Pain □ Discharge
□ Cancer

LUNGS: □ Decreased Exercise Tolerance □ Shortness of Breath
□ Wheezing □ Phlegm □ Coughing Up Blood
□ Cough

HEART: □ Chest Pain □ Difficulty Breathing When Lying Flat On Back
□ Leg Ulcers □ Bluish Tint to Lips or Fingertips
□ Palpitation □ Leg Cramps With Walking □ Leg Swelling

GASTROINTESTINAL: □ Vomiting Blood □ Difficulty Swallowing □ Abdominal Pain
□ Diarrhea □ Constipation □ Changes In Bowel Habits
□ Jaundice □ Food Intolerance □ Lack of Appetite
□ Nausea □ Bloody or Black Tarry Stools
□ Heartburn

ENDOCRINE: □ Increased Thirst □ Increased or Decreased Appetite
□ Glucose In Urine □ Hot or Cold All The Time
□ Impotence □ Thyroid Problems

ALLERGIES: □ Skin Rashes □ Eczema □ Other, please list

MUSCULOSKELETAL: □ Joint Pain □ Muscle Pain □ Joint Swelling
□ Stiffness □ Limited Range Of Motion
□ Injuries □ Back Or Flank Pain

NEUROLOGIC: □ Seizure(s) □ Fainting Spells □ Paralysis
□ Spasms □ Tremor □ Weakness of Arms or Legs
□ Incoordination □ Nerve Pain □ Changes In Sensation
□ Abnormal Gait □ Involuntary Movements
□ Numbness In Hands Or Feet

PSYCHIATRIC: □ Moodiness □ Anxiety □ Phobias
□ Memory Problems □ Judgment □ Depression
□ Other, please list

The information listed on this form is complete and correct to the best of my knowledge:

PATIENT SIGNATURE: _____

DATE: _____

THIS DOCUMENT HAS BEEN REVIEWED BY PHYSICIAN:

PHYSICIAN SIGNATURE: _____

DATE: _____