NEPHROLOGY PRACTICE
OF NIAGARA

HEALTH HISTORY

Patient Name: _____ MR#: _____

Date of Birth: _____ Age: _____ Sex: M _____ F _____

Home Phone: _____ Work Phone: _____ Email: _____

Referring Physician(s): _____ Phone: _____

Reason(s) for referral to this office: _____

Please list the names of all physicians you currently see:

_____ Phone: _____

_____ Phone: _____

_____ Phone: _____

MEDICATIONS

Your Pharmacy: _____ Phone: _____

List all medications (including dose and how often you take it):

Medication Name	Dosage	How often?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list all over the counter medications (examples: Tylenol, Advil) herbal supplements and vitamins you currently take:

OTC Medication Name	Dosage	How often?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Known Drug Allergies:_____

PREVIOUS MEDICAL HISTORY

Do you have any of the following?

Hypertension (High Blood Pressure) Yes ____ No ____
If yes, for how long? _____
Diabetes Yes ____ No ____
If yes, for how long? _____On Insulin Yes/ No Do you see a retina specialist? _____
Heart Disease:
History of a heart attack Yes ____ No ____
If yes, when? _____
Atrial fibrillation Yes ____ No ____
Heart failure Yes ____ No ____
Pacemaker Yes ____ No ____
History of an angioplasty? Yes ____ No ____
If yes, when? _____
Any other heart condition? Yes ____ No ___

List any surgeries:

Surgical Procedure	Date/Year	Surgeon/Physician Name
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

List other illnesses:

Illness	Date/Year	Illness	Date/Year

SOCIAL HISTORY

Married: _____ Single: _____ Divorced: _____ Widowed (er): Separated:

High Blood Pressure Yes ____ No ___

Are you currently working? Yes ___ No ___ No ____ Your Occupation: _____

Are you working full time? Yes ____ No ____ How many hours/day? _____

Do you currently smoke? Yes ____ No ____ _____ packs per day

Have you ever smoked? Yes ____ No ____ _____ packs per day

How long have/did you smoke? _____

Do you currently consume alcoholic drinks? Yes ____ No ____

How many alcoholic drinks do you consume per day? _____ Per week? _____

Check if any of your blood relatives had any of the following:

Disease			Relationship to you
Diabetes	Yes ____	No ___	_____
Heart Disease	Yes ____	No ___	_____
Stroke	Yes ____	No ___	_____
High Blood Pressure	Yes ____	No ___	_____
Kidney Disease	Yes ____	No ___	_____
Malignancy/Cancer	Yes ____	No ___	_____

NEPHROLOGY/UROLOGY *Check any that apply to **YOU**…*

History of Kidney Infections	Yes ____	No ___
Kidney Stones	Yes ____	No ___
Polycystic kidney disease?	Yes ____	No ___
History of Enlarged Prostate	Yes ____	No ___
Frequent Bladder Infections	Yes ____	No ___
History of Bladder Surgeries	Yes ____	No ___
If yes, why? _____		
Do you get up during the night to urinate?	Yes ____	No ___
If yes, how many times? _____		
Do you have burning when you urinate?	Yes ____	No ___
Do you see blood in your urine?	Yes ____	No ___
Have you been told you have protein in your urine?	Yes ____	No ___