Associates in Nephrology, S.C.

Patient Name:_____ **DOB:**_____

Past Medical History **e-mail:**_____

❑Kidney Disease		
❑Diabetes		
❑High Blood Pressure		
❑Ischemic Heart Disease		
❑Cancer		
❑Stroke		
❑Gout		
EENT	❑Blindness ❑Cataracts	❑Hearing Problems ❑Glaucoma
Cardiovascular	❑Atrial Fibrillation ❑Pacemaker	❑AICD ❑Valvular Heart Disease ❑Congestive Heart Failure ❑Mitral Valve Prolapse
Respiratory	❑COPD ❑Chronic Bronchitis ❑Asthma ❑Emphysema	❑Pneumonia ❑Tuberculosis ❑Sleep Apnea
Gastrointestinal	❑GERD ❑Stomach/Bowel Ulcers ❑Gall Bladder Disease ❑Hepatitis	❑Inflammatory Bowel Disease ❑Irritable Bowel Syndrome ❑Gluten Intolerance ❑Lactose Intolerance
Genitourinary	❑Enlarged Prostate	❑Kidney Stones ❑Frequent UTIs
Musculoskeletal	❑Osteoarthritis	❑Osteoporosis
Neurological	❑Multiple Sclerosis ❑Seizures	❑Parkinson's ❑Dementia
Psychiatric	❑Depression	❑Anxiety Disorder
Endocrine	❑Hypothyroidism	❑Hyperthyroidism ❑Adrenal Insufficiency
Hematology	❑Anemia ❑Sickle Cell Disease	❑Sickle Cell Trait ❑Blood Transfusion ❑Thalassemia
Immuno/Allergy	❑HIV ❑AIDS	❑Rheumatoid Arthritis ❑Lupus

Surgery History	❑Yes	❑No
Explain:		

Family History

Kidney Disease	❑Father	❑Sibling
❑None	❑Mother	❑Child
Diabetes	❑Father	❑Sibling
❑None	❑Mother	❑Child
High Blood Pressure	❑Father	❑Sibling
❑None	❑Mother	❑Child
Ischemic Heart Disease	❑Father	❑Sibling
❑None	❑Mother	❑Child
Cancer	❑Father	❑Sibling
❑None	❑Mother	❑Child
Stroke	❑Father	❑Sibling
❑None	❑Mother	❑Child
Gout	❑Father	❑Sibling
❑None	❑Mother	❑Child
ADPKD (polycystic kidney disease)	❑Father	❑Sibling
❑None	❑Mother	❑Child
Dementia	❑Father	❑Sibling
❑None	❑Mother	❑Child

Father		
❑Living	❑Deceased	❑Unknown
	Age at death: _____	
	Cause of death: _____	
Mother		
❑Living	❑Deceased	❑Unknown
	Age at death: _____	
	Cause of death: _____	

Social History

Current Marital Status	❑Married	❑Single	❑Divorced
	❑Separated	❑Widowed	
Living Arrangement	❑Alone	❑Spouse	❑Significant Other
	❑Family Member	❑In Home Caregiver	❑Assisted Living Facility
Occupation	❑Retired	❑Employed	❑F/Time ❑P/Time
	❑Unemployed	❑Student	
	Former/Current Occupation: _____		
Functional/Cognitive	❑No Impairment	❑Memory Deficit	
	❑Hearing Loss	❑Poor Vision or Blindness	
	❑Limited Mobility	❑Transportation Challenges	

Tobacco Use	❑Current Smoker	❑Former User	❑Never Used
Type	❑Cigarettes	❑Pipes	❑Cigars
	❑Chewing Tobacco	❑Snuff	
Frequency	❑Every day	❑Some days	
	Year Started:_____	Year Quit:_____	
Alcohol Use	❑Current User	❑Former User	❑Never Used
Amount	❑Occasional Social	❑1-2 drinks per day	❑>3 drink per day
	Year Quit:_____		
Recreational Drug Use	❑Current User	❑Former User	❑Never Used
Type	❑Marijuana	❑Heroin	❑Cocaine
	❑Amphetamines	❑Ecstasy	❑Barbiturates
	❑LSD	❑Opium	❑Other_____
	Year Quit:_____		

Immunizations

Flu	Administered?	❑Yes	❑No
	If yes, administered by: _____		
	Date administered: _____		
	If no, state reason: _____		
Pneumonia	Administered?	❑Yes	❑No
	If yes, administered by: _____		
	Date administered: _____		
	If no, state reason: _____		