HEALTH HISTORY

Fredericksburg Nephrology Associates, Inc.
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Patient Name_____Today's Date_____
Birthdate_____Date of last physical examination_____
What is your reason for visit? _____

Symptoms

Check (√) symptoms you currently have.

GENERAL
- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats
- ☐ Fatigue

MUSCLE/JOINT/ BONE
Pain, weakness, numbness in:
- ☐ Arms
- ☐ Back
- ☐ Feet
- ☐ Hands
- ☐ Hips
- ☐ Legs
- ☐ Neck
- ☐ Shoulders

Other Musculoskeletal
- ☐ Cold Extremities
- ☐ Difficulty walking

GASTROINESTINAL
- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

CARDIOVASULAR
- ☐ Chest pain
- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Swelling of feet, ankles, or hands
- ☐ Varicose veins
- ☐ Shortness of breath with walking or lying flat

EYE, EAR, NOSE, THROAT
- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Wears glasses
- ☐ Eye disease/injury
- ☐ Earache
- ☐ Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision-flashes
- ☐ Vision-halos

NEUROLOGICAL
- ☐ Frequent or reoccurring headaches
- ☐ Convulsions or seizures
- ☐ Numbness or tingling
- ☐ Head injury

RESPIRATORY
- ☐ Persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)
- ☐ Spitting up blood
- ☐ Shortness of breath
- ☐ Wheezing

GENITO-URINARY
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination
- ☐ Kidney stones

SKIN
- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Changes in moles
- ☐ Rash
- ☐ Scars
- ☐ Sore that won't heal
- ☐ Change in skin color

MEN ONLY
- ☐ Breast lump
- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore on penis
- ☐ 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 menstrual period?
_____
Date of last Pap Smear?
_____
Have you had a mammogram?
_____
Are you Pregnant? _____
Number of Children_____

Conditions

Check (√) conditions you currently have.

- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding disorders
- ☐ Breast lump
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical dependency
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate problem
- ☐ Psychiatric Care
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Vaginal infections
- ☐ Venereal disease

CONFIDENTIAL

TURN OVER ⇨

Medications/Dosages/Frequency

List medication you are currently taking.

_____

_____

_____

_____

_____

Allergies

_____

_____

_____

_____

_____

Family History

Fill in health information about your immediate family.

Relation	Age	State of Health	Age at Death	Cause of Death
Father				
Mother				
Brothers				
Sisters				

Check (√) if any of your blood relatives had any of the following: Disease	Relationship to you
☐ Arthritis, Gout	
☐ Asthma, Hay Fever	
☐ Cancer	
☐ Chemical Dependency	
☐ Diabetes	
☐ Heart Disease, Strokes	
☐ High Blood Pressure	
☐ Kidney Disease	
☐ Tuberculosis	
☐ Other	

Hospitalizations

Year	Hospital	Reason for Hospitalization and Outcome

Have you ever had a blood transfusion? _____

If yes, please give approximate dates _____

Serious illness/Injuries	Date	Outcome

Pregnancies

Year of Birth	Sex of birth	Complications if any

Health Habits

Check (√) which you use and how much you use.

☐	Caffeine	
☐	Tobacco	
☐	Street Drugs	
☐	Other	

Occupational

Occupation_____

Check (√) if your work exposes you to:

☐	Stress	☐	Hazardous Substances
☐	Heavy Lifting	☐	Other:

To the best of my knowledge, the above information is complete and correct. I understand that reporting incomplete or inaccurate information can be dangerous to my health. I understand that I am solely responsible for any errors or omissions that I may have made in the completion of this form. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

_____

Signature of Patient, Parent, guardian or Personal Representative

_____

Date

_____

Please Print name of Patient, Parent, guardian or Personal Representative

_____

Relationship to Patient