## **HEALTH HISTORY**

Fredericksburg Nephrology Associates, Inc.
Fredericksburg Office *P:(540)-371-3010 F:(540)-899-9821* Spotsylvania Office *P:(540)-898-4056 F:(540)-898-2956* 

Patient Name			Today's Date							
AgeBirth	ndate		Date of	last physi	cal examination					
What is your reason fo	or visit?									
Symptoms Check (V) symptoms you currently have.										
GENERAL	GASTRO	DINESTINAL	EYE, EAR, NO	OSE,	RESPIRATORY	MEN ONLY				
□ Chills	☐ Appeti	•	THROAT		☐ Persistent cough or	☐ Breast lump				
☐ Depression	☐ Bloating		☐ Bleeding gums		throat clearing not	☐ Erection difficulties				
☐ Dizziness		changes	☐ Blurred vision		associated with a	☐ Lump in testicles				
☐ Fainting	☐ Consti	•	☐ Crossed eye		known illness	☐ Penis discharge				
☐ Fever	☐ Diarrh		☐ Difficulty sv	_	(lasting more than 3 weeks)	☐ Sore on penis				
☐ Forgetfulness		ive hunger	☐ Double vision		☐ Spitting up blood	□ Other  WOMEN ONLY □ Abnormal Pap Smear □ Bleeding between periods				
☐ Headache		sive thirst	☐ Wears glasse		☐ Shortness of breath					
☐ Loss of sleep	□ Gas	1 ! 1.	☐ Eye disease/☐ Earache	injury	☐ Wheezing					
☐ Loss of weight	☐ Hemor									
<ul><li>□ Nervousness</li><li>□ Numbness</li></ul>	☐ Indiges		☐ Ear discharg☐ Hay fever	ge.						
☐ Sweats	☐ Rectal		☐ Hoarseness		GENITO-URINARY					
☐ Fatigue	☐ Stomac		☐ Loss of hearing		☐ Blood in urine	☐ Breast lump				
1 augue	□ Vomiti	_	□ Nosebleeds	1115	☐ Frequent urination	☐ Extreme menstrual pain				
	□ Vomiti	•	☐ Persistent co	ough	☐ Lack of bladder	☐ Hot flashes				
MUGGI E/IODE/		g 0100 <b>0</b>	☐ Ringing in e	_	control	☐ Nipple discharge				
MUSCLE/JOINT/ BONE			☐ Sinus problems		☐ Painful urination	☐ Painful intercourse				
Pain, weakness,	CARDIO	VASULAR	☐ Vision-flash	es	☐ Kidney stones	☐ Vaginal discharge				
numbness in:	☐ Chest 1	pain	☐ Vision-halos	8		→ □ Other				
□ Arms	☐ High b	lood pressure			SKIN	Date of last menstrual				
		ar heart beat			☐ Bruise easily	period?				
□ Feet		lood pressure			☐ Hives	Date of last Pap Smear?				
☐ Hands ☐ Poor c			NEUROLOGICAL  ☐ Frequent or reoccurring headaches  ☐ Convulsions or seizures		☐ Itching	Bate of fast 1 ap Sinear.				
r-		heart beat			☐ Changes in moles	Have you had a mammogram?  Are you Pregnant?				
☐ Legs ☐ Swelli					□ Rash					
L Neck		, or hands			□ Scars					
☐ Shoulders ☐ Varico		ess of breath			☐ Sore that won't heal					
Other Masearoskeretar		alking or lying			☐ Change in skin color	Number of				
☐ Cold Extremities	flat	arking or Tyling	☐ Numbness o			Children				
☐ Difficulty walking			☐ Head injury	y						
Conditions		(	Check (V) conditio	ns you curr	ently have.					
□ AIDS		☐ Chemic	cal dependency		High Cholesterol	☐ Prostate problem				
☐ Alcoholism		☐ Chicke	•		HIV Positive	☐ Psychiatric Care				
□ Anemia		☐ Diabete			Kidney disease	☐ Rheumatic Fever				
☐ Anorexia				Liver disease	☐ Scarlet Fever					
□ Appendicitis □					Measles	□ Stroke				
☐ Arthritis		☐ Glaucoma			Migraine Headaches	☐ Suicide Attempt				
□ Asthma		☐ Goiter			Miscarriage	☐ Thyroid Problems				
☐ Bleeding disorders		☐ Gonorrhea		_ I	Mononucleosis	☐ Tonsillitis				
☐ Breast lump		□ Gout			Multiple sclerosis	☐ Tuberculosis				
□ Bronchitis		☐ Heart d			Mumps	☐ Typhoid Fever				
□ Bulimia		☐ Hepatit	is		Pacemaker	□ Ulcers				
□ Cancer		☐ Hernia			Pneumonia	☐ Vaginal infections				
☐ Cataracts		☐ Herpes		_ I	Polio	☐ Venereal disease				

**CONFIDENTIAL** 



Medications 		List medication you are currently taking.							Allergie	·s		
								-				
Family	History	<b>/</b>		Fill	in health informatio	n about y	our im	mediat	e family.			
Relation	Age	State of Health	Age Deat		Cause of Death	Chec	k (v) if Disea		your blood	l relatives h		ny of the following: tionship to you
Father							Arthritis, Gout					- ·
Mother							Asth	ma, Ha	y Fever			
Brothers							Cancer					
							Chemical Dependency					
							Diab	iabetes				
								eart Disease, Strokes				
Sisters								n Blood Pressure				
							Kidney Disease				<u> </u>	
			1				Tuberculosis				<u> </u>	
Hospita	lination	.4					Othe		Pregnav	ania A	<u> </u>	
Year	Hospita			Reason	for Hospitalization	and	Yea		Sex of	Complica	tions	if any
- Cui	Позри	Trospitar			Reason for Hospitalization and Outcome			h	birth	Сотрпса		
							Hea	lth H	abits			
							Checl	eck ( $\forall$ ) which you use and how much y			h you use.	
								Caffe				,
		a blood transf pproximate d					_	Tobac	ссо			
								Street	t Drugs			
Serious illness/Injuries		s/Injuries	]	Date	Outcome			Other				
									pational			
								cupation Theck (V) if your work exposes you to:				
							Г					
							-	Heavy Lifting		;	+	Hazardous Substances Other:
understand t	that I cam so		for any er	rors or on								e dangerous to my health. I responsibility to inform my
Signature of Patient, Parent, guardian or Personal Representative							-			Da	te	<del></del>
Please Print name of Patient Parent guardian or Personal Representative						Relationship to Patient						