Kidney Care Specialists, LLC.
HEALTH HISTORY (Confidential)

Name:____ **Date Completed:** _______________

Age: ___________ **Date Of Birth:** _____________ **Date of Last Physical Exam:** _______________

*Symptoms: Check symptoms you currently have or have had in the past year

CONSTITUTIONAL	**GASTROINTESTINAL**	**NEUROLOGIC**	**HEMATOLOGIC**
Fever	Abdominal pain	Weakness	Abnormal bruising
Weight loss	Tenderness	Tingling	Abnormal bleeding
Weight gain	Abdominal mass	Numbness	**IMMUNOLOGIC**
Fatigue	Nausea & vomiting	Seizures	Seasonal allergies
Loss of appetite	Rectal bleeding	Dizziness	Abnormal rashes
Sweats	**GENITOURINARY**	Memory problems	Excessive itching
Headaches	Painful urination	Tremors	**SKIN**
Loss of sleep	Blood in the urine	**PSYCHIATRIC**	Rash
EYES	Urinary frequency	Depression	Itching
Change in vision	Urinary urgency	Suicidal ideation	**CARDIOVASCULAR**
Eye pain	Nocturia	**ENDOCRINE**	Chest pain
Light sensitivity	**MUSCULOSKELETAL**	Uncontrolled sugars	Shortness of breath
ENT	Weakness	Excessive thirst	Irregular pulse
Ringing in the ears	Cramps	Excessive hunger	Swelling of legs and feet
Nasal drainage	Muscle ache	Excessively hot	**RESPIRATORY**
Hearing loss	Joint pain	Excessively cold	Persistent cough

*Past Medical Conditions: Check conditions you have had in the past

Alcoholism	Diabetes	Migraine Headaches
Anemia	DVT	Mononucleosis
Anxiety	Emphysema	Neuromuscular Disease
Arthritis	Epilepsy	Neuropathy
Asthma	GI Disorder	Pace Maker Placement
Autoimmune Disease	Goiter	Polio
Bleeding Disorder	Gout	Polycystic Kidney Disease
Cancer	Hepatitis	Prostate Disorder
Chemical Dependency	Hernia	Reoccurring UTIs
Coronary Artery Disease	High Cholesterol	Retinopathy
Congestive Heart Failure	Hypertension	Sleep Apnea
Chronic Kidney Disease	HIV Positive	Stroke
Depression	Kidney Stones	Thyroid Disease

***MEDICATIONS: List what you're currently taking, dose and frequency**

***ALLERGIES: Medication/Reaction**

*FAMILY HISTORY: Fill in health information about your family: ☐ History is unknown

Relation	Age	State of Health	Age at Death	Cause of Death	Check if your blood relatives had any of the following Disease	Relationship to you
Father					Anemia	
Mother					Arthritis	
Brothers					Cancer	
					Chemical Dependency	
					Coronary Artery Disease	
					Diabetes	
Sisters					Heart Disease	
					High Blood Pressure	
					High Cholesterol	
					Kidney Disease	
Children					Kidney Stones	
					Strokes	
					Tuberculosis	
					Other	

*HOSPITALIZATIONS/SURGERY/PROCEDURES

Year	Hospital	Reason for Hospitalization

*PREGANANCY HISTORY

Year	M or F	Complications if any

Have you ever had a *blood transfusion*? ☐ Yes ☐ No
If yes, Please give approximate dates.

SERIOUS ILLNESS/INJURY	DATE

*SOCIAL HISTORY: Check which substance you use

How much? How often? Former user?

Alcohol	
Caffeine	
Tobacco	
Drugs	
Other	

*OCCUPATIONAL CONCERNS:

Check if your work exposes you to the following:

	Stress
	Hazardous Substances
	Heavy Lifting
	Other

MARITAL STATUS: ___________________________________

WHO DO YOU LIVE WITH: _____________________________

YOUR OCCUPATION: _________________________________

EXERCISE LEVEL: ___________________________________

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature ____ Date _____________

Reviewed By: ____ Date _____________