NAMC
NEPHROLOGY ASSOCIATES OF MONTGOMERY COUNTY

Nephrology Associates of Montgomery County

Kidney Diseases and Hypertension

MEDICAL HISTORY FORM

PLEASE FILL OUT THE FORM AS ACCURATELY AS POSSIBLE.
THE INFORMATION WILL BE ENTERED INTO YOUR PERMANENT RECORD

NAME:_________________________ **DOB:** ____________________

A. DO YOU HAVE:

	YES	NO	M.D. NOTES
KNOWN KIDNEY DISEASE	☐	☐	______________
URINATION AT NIGHT	☐	☐	______________
FREQUENT URINATION	☐	☐	______________
BURNING ON URINATION	☐	☐	______________
DIFFICULTY URINATING	☐	☐	______________
SINUSITIS	☐	☐	______________
PROTEIN / FOAMY URINE	☐	☐	______________
BLOOD IN URINE	☐	☐	______________
KIDNEY STONES	☐	☐	______________

	YES	NO	M.D. NOTES
DIABETES IN EYES (Laser Treatment)	☐	☐	______________
DIABETES IN NERVES (Neuropathy)	☐	☐	______________
PROSTATE INFECTION	☐	☐	______________
PAIN WITH WALKING (PAD/PVD)	☐	☐	______________
HEARING LOSS	☐	☐	______________
KIDNEY/BLADDER INFECTION	☐	☐	______________
HERBAL MEDICINES	☐	☐	______________
CHILDHOOD NEPHRITIS	☐	☐	______________
CONSISTENT USE OF Non-Steroidal	☐	☐	______________

(Motrin, Ibuprofen, Aleve, Goody, Naproxen, Indocin, Mobic, Excedrin)

B. LIST MEDICAL PROBLEMS WITH APPROXIMATE YEAR WHEN DIAGNOSED:

Medical Problem	Year
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	

C. PLEASE LIST MEDICINES INCLUDING OVER THE COUNTER AND HERBALS AND/OR BRING TO CLINIC VISIT:

Medication with dose and frequency per day
1.
2.
3.
4.
5.
6.
7.
8.
9.
10.

D. ALLERGIES AND TYPE OF REACTION: ____

____

____

E. FAMILY HISTORY:

	YES	NO	Relationship
KIDNEY DISEASE	☐	☐	____________________
HEART ATTACK	☐	☐	____________________
HIGH BLOOD PRESSURE	☐	☐	____________________
GOUT	☐	☐	____________________
KIDNEY TRANSPLANT	☐	☐	____________________

	YES	NO	Relationship
DIABETES	☐	☐	____________________
CANCER	☐	☐	____________________
STROKE	☐	☐	____________________
LUPUS	☐	☐	____________________
DIALYSIS	☐	☐	____________________

MEDICAL HISTORY FORM

F. SOCIAL HISTORY:

HAVE YOU EVER SMOKED? YES ☐ NO ☐ PACKS PER DAY: ________ FOR ________ YEARS QUIT IN ____________
DO YOU DRINK ALCOHOL? YES ☐ NO ☐ DRINKS PER DAY: ________ FOR ________ YEARS QUIT IN ____________
ARE YOU: SINGLE / MARRIED / DIVORCED / WIDOWED ☐ RETIRED OCCUPATION:______________________________

G. REVIEW OF SYMPTOMS (CHECK ANY THAT REGULARLY OCCUR):

GENERAL:
☐ FATIGUE
☐ FEVER
☐ CHILLS
☐ NIGHT SWEATS
☐ CHANGE IN APPETITE OR WEIGHT

HEART:
☐ HEART ATTACK
☐ IRREGULAR. OR RAPID HEART BEAT
☐ CHEST PAIN OR TIGHTNESS
☐ MURMUR
☐ TROUBLE LYING FLAT

ENDOCRINOLOGIC:
☐ THYROID DISEASE
☐ HOT/COLD SENSITIVITY
☐ EXCESSIVE WATER DRINKING

HEENT:
☐ MIGRAINES
☐ SEVERE HEADACHE
☐ LOSS OF CONSCIOUSNESS
☐ RINGING IN THE EARS
☐ BLURRY VISION
☐ DOUBLE VISION
☐ HAYFEVER/SINUSITIS
☐ NOSE BLEEDS
☐ FREQUENT SORE THROAT
☐ HOARSENESS

GASTROINTESTINAL:
☐ DIVERTICULI/HEMMORHOIDS
☐ ULCERS
☐ DIARRHEA
☐ CONSTIPATION
☐ VOMITING BLOOD
☐ LIVER DISEASE/HEPATITIS
☐ BLACK TARRY STOOL OR BLOOD IN STOOL
☐ TROUBLE SWALLOWING

HEMATOLOGIC:
☐ ANEMIA
☐ EASY BRUISING
☐ BLOOD TRANSFUSION
☐ SWOLLEN LYMPH GLANDS
☐ BLOOD CLOT

JOINT:
☐ SWOLLEN JOINTS
☐ WEAKNESS
☐ ARTHRITIS
☐ OSTEOPOROSIS
☐ BACK PAIN
☐ MUSCLE PAIN
☐ RASHES

PULMONARY:
☐ ASTHMA
☐ TUBERCULOSIS
☐ WHEEZING
☐ PERSISTENT COUGH
☐ COUGHING UP BLOOD
☐ UNRESOLVING PNEUMONIA
☐ SHORTNESS OF BREATH WITH EXERCISE
☐ ASBESTOS / SILICA CONTACT

NEUROLOGIC:
☐ SEIZURES
☐ NUMBNESS
☐ STROKE
☐ VERTIGO
☐ LOSS OF BALANCE
☐ PSYCHOLOGIC TREATMENT

OTHERS: ____

Notes (for office use only):

____
____
____
____
____
____