Ohio Kidney Consultants, Inc.
Health History Questionnaire

Name: ______________________________
Prefer to be called: ______________________
Date of Birth: __________ ***Age***: _____
Marital Status:
□ Single □ Married □ Widowed □ Divorced □ Separated
Employment:
□ Full-time □ Part-time □ Retired □ Disability
Employer: ______________________________
Job Description: __________________________

Primary Care Doctor: ______________________
Heart Doctor: ______________________
Diabetes Doctor: ______________________
Urologist: ______________________
Surgeon: ______________________
Other Doctors: ______________________

Is there a family history of:		List Relative(s)
Kidney Disease?	□ Yes □ No	______________
Kidney Stones?	□ Yes □ No	______________
Dialysis?	□ Yes □ No	______________
High blood pressure?	□ Yes □ No	______________
High cholesterol?	□ Yes □ No	______________
Heart disease?	□ Yes □ No	______________
Diabetes?	□ Yes □ No	______________
Cancer?	□ Yes □ No	______________
Stroke?	□ Yes □ No	______________
Anemia?	□ Yes □ No	______________
Hearing Loss?	□ Yes □ No	______________
Lupus?	□ Yes □ No	______________

Personal Health History	
Exercise	□ Sedentary (no exercise)
	□ Mild (i.e., climb stairs, golf, walk 3 blocks)
	□ Occasional vigorous (<4x/wk for 30 min)
	□ Regular vigorous (>4x/wk for 30 min)
Dieting? □ Yes □ No	Type:
Salt Intake	□ High □ Medium □ Low
Caffeine	□ None □ Coffee □ Tea □ Cola
	# cups/cans per day?
Alcohol □ Yes □ No	# drinks per week?
Tobacco □ Yes □ No □ Former	□ Cigarettes – list # packs per day □ Chew – list # per day □ Pipe / Cigars – list # per day
	□ Number of years □ Year quit
Drugs	Currently use street/recreational drugs? □ Yes □ No
	Ever used street/recreational drugs? □ Yes □ No
	Ever injected drugs with a needle? □ Yes □ No
Exposures	Ever had yellow jaundice or hepatitis? □ Yes □ No
	Ever had a blood transfusion? □ Yes □ No When?
	Ever been exposed to heavy metals? □ Lead □ Mercury □ Cadmium □ Other

Family Health History		
	Age	**Health Problems**
Father	Alive Dead	
Mother	Alive Dead	
Brothers	Alive Dead	
	Alive Dead	
	Alive Dead	
Sisters	Alive Dead	
	Alive Dead	
	Alive Dead	
Sons	Alive Dead	
	Alive Dead	
	Alive Dead	
Daughters	Alive Dead	
	Alive Dead	
	Alive Dead	

Preventative Services & Dates:
□ Colonoscopy ______________
□ Mammogram ______________
□ Rectal Exam ______________

Physician Signature ______________________
Date ______________________

Please list drug and food allergies, along with adverse reactions: □ None

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Please list any medication prescribed by a physician, any over-the-counter (non-prescription) medications, as well as any vitamin/mineral/nutritional supplements that you take on a regular basis. Use extra sheet of paper if necessary.

Medication	Dose	Frequency (times per day)	Started	Stopped
Example: Lasix	20 mg	1 pill 2 times a day	6/1/05	---------

Which of the following conditions are you currently being treated or have been treated for in the past (please check)?

□ Anemia
□ Arthritis (age related)
□ Asthma
□ Atrial fibrillation
□ Blood clots
□ Cancer__________________
□ Diabetes
□ Dialysis
□ Emphysema / COPD
□ Gout
□ Heart disease / Angina
□ Heart failure
□ High blood pressure
□ High cholesterol
□ Kidney problems
□ Kidney stones
□ Liver problems / Hepatitis
□ Lung problems
□ Lupus
□ Migraines
□ Neuropathy
□ Osteoporosis
□ Peripheral vascular disease
□ Prematurity/ low birth weight
□ Pre-eclampsia
□ Prostate cancer
□ Prostate enlargement
□ Rheumatoid arthritis
□ Seizures
□ Sinus problems
□ Sleep apnea
□ Stomach ulcers
□ Stroke
□ Thyroid problems
□ Toxemia of pregnancy
□ Urine/bladder infections

Please describe any current or past medical treatments not listed above:

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Previous Operations	Date	Age	Reason	Complications?

Have you used any of the following medications in the past on a daily basis (please check)?

□ Acetamenophen
□ Advil
□ Aleve
□ Ansaid
□ Arthrotec
□ Aspirin
□ Bextra
□ Celebrex
□ Daypro
□ Diclofenac
□ Etodolac
□ Feldene
□ Ibuprofen
□ Indocin
□ Indomethacin
□ Ketorolac
□ Lodine
□ Meloxicam
□ Mobic
□ Motrin
□ Naprosyn
□ Naproxen
□ Oxaprozin
□ Piroxicam
□ Relafen
□ Sulindac
□ Toradol
□ Tylenol
□ Vioxx
□ Voltaren

Review of Symptoms (please circle response)

Constitutional

General good health	No	Yes
Recent weight loss (# lbs______)	No	Yes
Recent weight gain (# lbs______)	No	Yes
Fever	No	Yes
Chills	No	Yes
Sweats	No	Yes
Fatigue	No	Yes
Loss of energy	No	Yes

Head

Headaches	No	Yes
Migraines	No	Yes
Dizziness	No	Yes
Neck stiffness	No	Yes
Jaw pain	No	Yes
Hair loss	No	Yes

Eyes

Dry eyes	No	Yes
Light sensitivity	No	Yes
Double vision	No	Yes
Blurred vision	No	Yes
Wear glasses	No	Yes

Date of last eye exam: _______________

Surgeries: _________________________

Laser surgeries:_____________________

Ears

Hearing loss	No	Yes
Hearing aids	No	Yes
Recurrent infections	No	Yes
Vertigo	No	Yes

Nose

Runny nose	No	Yes
Nasal stuffiness	No	Yes
Recurrent sinus infections	No	Yes
Postnasal drip	No	Yes
Nasal polyps	No	Yes
Nosebleeds	No	Yes
Snoring	No	Yes

Surgeries: ___________________________

Throat / Mouth

Frequent sore throats	No	Yes
Dry mouth	No	Yes
Metallic taste	No	Yes
Abnormal taste	No	Yes
Sores in mouth	No	Yes

Cardiovascular

Heart trouble	No	Yes
Chest pain / angina	No	Yes
Chest pressure	No	Yes
Palpitations	No	Yes
Racing heart	No	Yes
Short of breath laying flat	No	Yes
Ankle / leg swelling	No	Yes
Ulcers of feet / legs	No	Yes
Leg pain when walking	No	Yes

Pulmonary

Chronic or frequent cough	No	Yes
Sputum production	No	Yes
Coughing up blood	No	Yes
Shortness of breath	No	Yes
Asthma / wheezing	No	Yes

Gastrointestinal

Loss of appetite	No	Yes
Change in taste sensation	No	Yes
Difficulty swallowing	No	Yes
Nausea / vomiting	No	Yes
Heartburn	No	Yes
Abdominal pain	No	Yes
Change in bowel habits	No	Yes
Constipation	No	Yes
Diarrhea	No	Yes
Blood in stool	No	Yes
Dark or tarry stool	No	Yes

Genitourinary

Urinate a lot	No	Yes
Inability to hold urine	No	Yes
Hesitancy during urination	No	Yes
Slow stream	No	Yes
Weak stream	No	Yes
Dribbling	No	Yes
Frequent urination	No	Yes
Burning upon urination	No	Yes
Frequent night urination	No	Yes
Blood in urine	No	Yes
Repeated urine infections	No	Yes
Kidney stones	No	Yes
Kidney infections	No	Yes
Excessive thirst	No	Yes
Excessive volume of urine	No	Yes
Foamy or bubbly urine	No	Yes
Protein in urine	No	Yes

Musculoskeletal

Joint pain	No	Yes
Joint stiffness	No	Yes
Joint swelling	No	Yes
Joint redness	No	Yes
Muscle loss (atrophy)	No	Yes
Muscle cramps	No	Yes
Sciatica	No	Yes
Weakness of muscles/joints	No	Yes
Bone pain	No	Yes
Difficulty walking	No	Yes
Color change in fingers	No	Yes
Color change in feet	No	Yes

Neurological

Frequent headaches	No	Yes
Lightheaded or dizzy	No	Yes
Convulsions or seizures	No	Yes
Excessive sleepiness	No	Yes
Restless legs	No	Yes
Numbness or tingling	No	Yes
Tremors	No	Yes
Paralysis	No	Yes

Endocrine

Thyroid disease	No	Yes
Heat intolerance	No	Yes
Cold intolerance	No	Yes
Hair loss	No	Yes

Skin

Hives	No	Yes
Eczema	No	Yes
Itching	No	Yes
Rashes	No	Yes
Lumps	No	Yes
Nail changes	No	Yes
Increased hair growth	No	Yes
Increased skin pigment	No	Yes

Psychiatric

Confusion	No	Yes
Memory loss confusion	No	Yes
Nervousness / anxiety	No	Yes
Insomnia	No	Yes
Depression	No	Yes

Hematological

Blood clot	No	Yes
Easy bleeding	No	Yes
Easy bruising	No	Yes
Prolonged bleeding	No	Yes