Riverside Nephrology Associates, 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)?

□ Acute Renal Failure	□ Emphysema / COPD	□ Lung problems	□ Rheumatoid arthritis
□ Anemia	□ Gout	□ Lupus	□ Seizures
□ Arthritis (age related)	□ Heart disease / Angina	□ Migraines	□ Sinus problems
□ Asthma	□ Heart failure	□ Neuropathy	□ Sleep apnea
□ Atrial fibrillation	□ High blood pressure	□ Osteoporosis	□ Stomach ulcers
□ Blood clots	□ High cholesterol	□ Peripheral vascular disease	□ Stroke
□ Cancer (list type)	□ Kidney problems	□ Pre-eclampsia	□ Thyroid problems
□ Diabetes	□ Kidney stones	□ Prostate cancer	□ Toxemia of pregnancy
□ Dialysis	□ Liver problems / Hepatitis	□ Prostate enlargement	□ 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	□ Bextra	□ Fenoprofen	□ Lodine	□ Orudis	□ Sulindac
□ Advil	□ Celebrex	□ Flurbiprofen	□ Meloxicam	□ Oruvail	□ Toradol
□ Alleve	□ Celecoxib	□ Ibuprofen	□ Mobic	□ Oxaprozin	□ Tylenol
□ Anaprox	□ Daypro	□ Indocin	□ Motrin	□ Piroxicam	□ Valdecoxib
□ Ansaid	□ Diclofenac	□ Indomethacin	□ Nabumetone	□ Relafen	□ Vioxx
□ Arthrotec	□ Etodolac	□ Ketoprofen	□ Naprosyn	□ Rofecoxib	□ Voltaren
□ Aspirin	□ Feldene	□ Ketorolac	□ Naproxen	□ Salsalate	

Review of Symptoms (please circle response)

Constitutional

Fever	No	Yes
Chills	No	Yes
Recent weight loss (# lbs______)	No	Yes
Recent weight gain (# lbs______)	No	Yes
Malaise/Fatigue	No	Yes
Loss of energy	No	Yes
Sweats	No	Yes
Weakness	No	Yes

Skin

Rashes	No	Yes
Itching	No	Yes
Color change	No	Yes
Wound	No	Yes

HENT

Hearing loss	No	Yes
Tinnitis	No	Yes
Ear pain	No	Yes
Ear discharge	No	Yes
Nosebleeds	No	Yes
Congestion	No	Yes
Stridor	No	Yes
Sore throat	No	Yes
Hoarseness	No	Yes

Eyes

Vision impaired	No	Yes
Blurred vision	No	Yes
Double vision	No	Yes
Light sensitivity	No	Yes
Eye pain	No	Yes
Eye discharge	No	Yes
Eye redness	No	Yes

Cardiovascular

Chest pain / angina	No	Yes
Palpitations	No	Yes
Short of breath laying flat	No	Yes
Leg pain with walking	No	Yes
Leg swelling	No	Yes

Pulmonary

Cough	No	Yes
Coughing up blood	No	Yes
Sputum production	No	Yes
Shortness of breath	No	Yes
Wheezing	No	Yes

Gastrointestinal

Heartburn	No	Yes
Poor appetite	No	Yes
Difficulty swallowing	No	Yes
Nausea	No	Yes
Vomiting	No	Yes
Abdominal pain	No	Yes
Diarrhea	No	Yes
Constipation	No	Yes
Blood in stool	No	Yes
Dark or tarry stool	No	Yes

Genitourinary

Burning upon urination	No	Yes
Urgency	No	Yes
Frequency	No	Yes
Urinary hesitancy	No	Yes
Urinary incontinence	No	Yes
Frequent night urination	No	Yes
Blood in urine	No	Yes
Flank pain	No	Yes

Musculoskeletal

Muscle pain	No	Yes
Muscle cramps	No	Yes
Neck pain	No	Yes
Back pain	No	Yes
Joint pain	No	Yes
Falls	No	Yes

Endo/Heme/Allergy

Easy bruise/bleed	No	Yes
Environmental allergies	No	Yes
Frequent thirst	No	Yes
Heat intolerance	No	Yes
Cold intolerance	No	Yes

Neurological

Dizzy	No	Yes
Headaches	No	Yes
Numbness	No	Yes
Tingling	No	Yes
Tremors	No	Yes
Sensory change	No	Yes
Speech change	No	Yes
Focal weakness	No	Yes
Seizures	No	Yes
Loss of consciousness	No	Yes

Psychiatric

Depression	No	Yes
Suicidal ideas	No	Yes
Substance abuse	No	Yes
Hallucinations	No	Yes
Nervous/anxious	No	Yes
Insomnia	No	Yes
Memory loss	No	Yes