Northwest Nephrology Clinic

Medical History Form

Name: _____ Date of Birth: _____

Allergies: _____

Medications: (please specify name, strength and dose):

_____ _____
_____ _____
_____ _____
_____ _____

Past Medical History: (include dates diagnosed)

- □ High Blood Pressure
- □ Heart Disease
- □ Pacemaker/Defibrillator
- □ Congestive Heart Failure
- □ Palpitations
- □ Stroke
- □ Seizures
- □ Asthma
- □ Thyroid Disease
- □ Headaches
- □ Sinus Problems
- □ Glaucoma
- □ Hearing Loss
- □ Lupus
- □ Anemia
- □ Gastrointestinal Bleeding
- □ GERD
- □ Cancer (type) _____
- □ COPD
- □ Kidney Stones
- □ Kidney Disease
- □ Hepatitis _____
- □ Gall Bladder Disease
- □ Arthritis (Osteoarthritis or Rheumatoid)
- □ Gout
- □ Depression
- □ Bipolar Disorder
- □ Anxiety
- □ Breast Disease _____
- □ Prostate Disease _____
- □ Erectile Dysfunction
- □ Diabetes □ Insulin dependent
- □ Skin Disease
- □ Blood Clots

List any surgeries or hospitalizations and the dates:

_____
_____
_____

Family History:

	Living		Age (or age at death)	Medical History
Father	□ Yes	□ No	_____	_____
Mother	□ Yes	□ No	_____	_____
Sisters	□ Yes	□ No	_____	_____
Brothers	□ Yes	□ No	_____	_____

Name_____ Date of Birth _____

Personal Health History

History of tobacco use _____ How many _____packs/day # of years _____
Year quit _____
History of alcohol use _____ How much _____drinks/week # of years _____
Year quit _____
History of drug abuse _____

Social History

Work: ☐ Employed ☐ Unemployed ☐ Retired ☐ Disabled

Occupation: _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widow ☐ Domestic Partner

Children (age):

Sons:

_____

Daughters:

_____

Hobbies:

_____

_____

Sports:

_____

_____

Religion Preference:

_____