

# Capital Nephrology Associates

## Patient Medical Health History

Patient Name \_\_\_\_\_ Date: \_\_\_\_\_

Age \_\_\_\_\_ Birth date \_\_\_\_\_ Date of last physical exam \_\_\_\_\_

What is your reason for your visit today? \_\_\_\_\_

SYMPTOMS check (✓) symptoms you currently have or have in the past year

<u>General</u>		<u>Skin</u>	<u>Conditions</u>
<input type="checkbox"/> Weight Loss	<input type="checkbox"/> Nausea/Vomiting	<input type="checkbox"/> Rash	<input type="checkbox"/> AIDS
<input type="checkbox"/> Weigh Gain	<input type="checkbox"/> Constipation/Diarrhea	<input type="checkbox"/> Itching	<input type="checkbox"/> Alcoholism
<input type="checkbox"/> Night Sweats	<input type="checkbox"/> Ulcers	<input type="checkbox"/> Bruising	<input type="checkbox"/> Anemia
<input type="checkbox"/> TB Exposure	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Moles	<input type="checkbox"/> Anorexia
<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Body Pain	<u>Eye &amp; ENT</u>	
<input type="checkbox"/> Asthma/Emphysema	<input type="checkbox"/> Weakness	<input type="checkbox"/> Blurred Vision	<input type="checkbox"/> Appendicitis
<input type="checkbox"/> Coughing up Blood	<input type="checkbox"/> Gout	<input type="checkbox"/> Glasses	<input type="checkbox"/> Arthritis
<input type="checkbox"/> Painful Breathing	<input type="checkbox"/> Loss of Appetite	<input type="checkbox"/> Contacts	<input type="checkbox"/> Asthma
<input type="checkbox"/> Chest Pains	<input type="checkbox"/> Increase of Appetite	<input type="checkbox"/> Eye Surgery	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Chest Pressure	<input type="checkbox"/> Hair Loss	<input type="checkbox"/> Nosebleeds	<input type="checkbox"/> Epilepsy
<input type="checkbox"/> Chest Tightness/dizzy	<input type="checkbox"/> Thirsty	<input type="checkbox"/> Trouble Swallowing	<input type="checkbox"/> Heart Disease
<input type="checkbox"/> Lightheaded/Palpitations	<input type="checkbox"/> Heavy Urination	<input type="checkbox"/> Ringing Ears	<input type="checkbox"/> Hepatitis
<input type="checkbox"/> Blood Clots	<input type="checkbox"/> Blood In Urine	<input type="checkbox"/> Trouble Hearing	<input type="checkbox"/> Herpes
<input type="checkbox"/> Calf Pain	<input type="checkbox"/> Uncontrolled Urine		<input type="checkbox"/> High Cholesterol
<input type="checkbox"/> Cold Hands or Feet	<input type="checkbox"/> Weak Stream		<input type="checkbox"/> HIV Positive
<input type="checkbox"/> Smoker			<input type="checkbox"/> Migraine Headache
			<input type="checkbox"/> Prostate Problem
			<input type="checkbox"/> Thyroid Problem
			<input type="checkbox"/> Tuberculosis
			<input type="checkbox"/> Thyroid Fever

### Medical History

Please identify who was affect by condition: Mother, Father or Siblings

High Blood Pressure _____	Anemia _____
Diabetes _____	Arthritis _____
Kidney Failure _____	Gout _____
Kidney Stones _____	Lupus _____
Thyroid Disease _____	Cancer _____
Heart Failure _____	Liver Disease _____
Heart Attacks _____	Kidney Biopsy _____
Kidney Ultrasound _____	

Last time you had blood drawn was when and where? \_\_\_\_\_

List your allergies \_\_\_\_\_

*I hereby state, to the best of my knowledge, that these questions were answered truthfully. I understand the information to be used to complete my medical history and to aid diagnosis and treatment process.*

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_