Northwest Nephrology Clinic

Medical History Form

Name: _____ Date of Birth: _____

Allergies: _____

Pharmacy: _____

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

_____ _____
_____ _____
_____ _____
_____ _____

Past Medical History: (include dates diagnosed)

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