NORTHWEST NEPHROLOGY CLINIC

MEDICAL HISTORY FORM

Date: _____

Patient Name: _____

Date of Birth: _____

Allergy: _____ Reaction: _____

Allergy: _____ **Reaction:** _____

Current List of Medications (Please list name/dose/frequency)

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Family History:

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

Personal Health History

History of tobacco use_____ How much _____packs/day No. of years _____
Year you quit _____

History of alcohol use _____ How much _____drinks/week No. of years _____
Year you quit _____

History of drug use _____

Past Surgical History (indicate date if known)

☐ None
☐ Tonsillectomy _____
☐ Adenoidectomy _____
☐ Cardiac Stents _____
☐ Defibrillator _____
☐ Appendectomy _____
☐ Hemorrhoidectomy _____
☐ Hysterectomy _____
☐ Colonoscopy _____
☐ Spinal Surgery _____
☐ Orthopedic/joints _____
☐ Other _____
☐ Cataracts _____
☐ Thyroidectomy _____
☐ Coronary Bypass _____
☐ Pacemaker _____
☐ Gall Bladder _____
☐ Bowel /Stomach Resection _____
☐ Bariatric Surgery _____
☐ Endoscopy _____
☐ Hernia _____
☐ Bladder Surgery _____
☐ Prostate Surgery _____

Patient Name: _____ **Date of Birth:** _____

Past Medical History:

Headaches	☐ Yes	☐ No
Sinus Problems	☐ Yes	☐ No
Stroke	☐ Yes	☐ No
Seizures	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Thyroid Disease	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No
Hearing Loss	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No
Blood Clots	☐ Yes	☐ No
Heart Burn/Reflux	☐ Yes	☐ No
Stomach Ulcers	☐ Yes	☐ No
Heart Disease	☐ Yes	☐ No
☐ Coronary Disease	☐ Yes	☐ No
☐ MI/Heart Attack	☐ Yes	☐ No
☐ Congestive Heart Failure	☐ Yes	☐ No
☐ Atrial Fibrillation	☐ Yes	☐ No
☐ Angina	☐ Yes	☐ No
☐ Valve Disorder	☐ Yes	☐ No
High Cholesterol	☐ Yes	☐ No
Lupus	☐ Yes	☐ No
Anemia	☐ Yes	☐ No
Kidney Stones	☐ Yes	☐ No
Gastrointestinal Bleeding	☐ Yes	☐ No
Hepatitis (A, B, C)	☐ Yes	☐ No
Chronic Wounds	☐ Yes	☐ No
Cancer	☐ Yes	☐ No
☐ Breast	☐ Yes	☐ No
☐ Ovarian	☐ Yes	☐ No
☐ Prostate	☐ Yes	☐ No
☐ Lung	☐ Yes	☐ No
☐ Throat	☐ Yes	☐ No
☐ Kidney	☐ Yes	☐ No
UTI	☐ Yes	☐ No
Kidney Stones	☐ Yes	☐ No
COPD	☐ Yes	☐ No
Asthma	☐ Yes	☐ No
Depression	☐ Yes	☐ No
Bipolar Disorder	☐ Yes	☐ No
Anxiety	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No
Gout	☐ Yes	☐ No
Osteoporosis	☐ Yes	☐ No
Prostate Disease	☐ Yes	☐ No
Breast Disease	☐ Yes	☐ No
Erectile Dysfunction	☐ Yes	☐ No

Patient Name: _____ **Date of Birth:** _____

Social History:

Work: □ Employed □ Unemployed □ Retired □ Disabled

Occupation: _____

Marital Status: □ Married □ Single □ Divorced □ Domestic Partner

Children (age):

_____

_____

Hobbies:

_____

_____

Sports:

_____

_____

Religious Preference: _____