

PENINSULA KIDNEY ASSOCIATES
HEALTH HISTORY
 (CONFIDENTIAL)

Name: _____ Date: _____

Date of Birth: _____ Age: _____ Date of Last Physical: _____

Conditions: Check (X) conditions you currently have or have had in the past.

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Aids | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Measles | <input type="checkbox"/> Stoke |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Migraine
Headaches | <input type="checkbox"/> Suicide
Attempt |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Thyroid
Problems |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Goiter | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Multiple
Sclerosis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Bleeding
Disorders | <input type="checkbox"/> Gout | <input type="checkbox"/> Mumps | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Urinary Tract
Infection |
| <input type="checkbox"/> Bulimia | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Vaginal
Infections |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hernia | <input type="checkbox"/> Polio | <input type="checkbox"/> Venereal
Disease |
| <input type="checkbox"/> Cardiovascular
Disease | <input type="checkbox"/> Herpes | <input type="checkbox"/> Prostate
Problems | |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> High Blood
Pressure | <input type="checkbox"/> Psychiatric
Area | |
| <input type="checkbox"/> Chemical
Dependency | <input type="checkbox"/> High
Cholesterol | <input type="checkbox"/> Rheumatic
Fever | |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> HIV Positive | | |
| <input type="checkbox"/> Dementia | <input type="checkbox"/> Kidney
Disease | | |

Past Surgical History/ Hospitalizations Please include Procedure and Date.

- | | |
|---|---|
| <input type="checkbox"/> Abdominal _____ | <input type="checkbox"/> GYN _____ |
| <input type="checkbox"/> Bladder _____ | <input type="checkbox"/> Neurosurgery _____ |
| <input type="checkbox"/> Cardiac _____ | <input type="checkbox"/> Orthopedic _____ |
| <input type="checkbox"/> Cardiovascular _____ | <input type="checkbox"/> Prostate _____ |
| <input type="checkbox"/> Colon _____ | <input type="checkbox"/> Renal _____ |
| <input type="checkbox"/> ENT _____ | <input type="checkbox"/> Thyroid _____ |
| <input type="checkbox"/> Gastrointestinal _____ | <input type="checkbox"/> Vascular _____ |

Medications Please List Dosage

Allergies:

Family Medical History: fill in health information about your family.

	Mother	Father	Sibling	Grandmother	Grandfather
<input type="checkbox"/> Arthritis	_____	_____	_____	_____	_____
<input type="checkbox"/> Asthma	_____	_____	_____	_____	_____
<input type="checkbox"/> Cancer	_____	_____	_____	_____	_____
<input type="checkbox"/> Diabetes	_____	_____	_____	_____	_____
<input type="checkbox"/> Heart Disease	_____	_____	_____	_____	_____
<input type="checkbox"/> High Blood Pressure	_____	_____	_____	_____	_____
<input type="checkbox"/> Stroke	_____	_____	_____	_____	_____
<input type="checkbox"/> Kidney Disease	_____	_____	_____	_____	_____
<input type="checkbox"/> Tuberculosis	_____	_____	_____	_____	_____
<input type="checkbox"/> Other	_____	_____	_____	_____	_____

Social History: Please check (X) all that apply

- | | | |
|---------------------------------------|--|--------------------------------------|
| <input type="checkbox"/> Alcohol | <input type="checkbox"/> Depressants | <input type="checkbox"/> Narcotics |
| <input type="checkbox"/> Amphetamines | <input type="checkbox"/> Ecstasy | <input type="checkbox"/> Stimulants |
| <input type="checkbox"/> Barbiturates | <input type="checkbox"/> Hallucinogens | <input type="checkbox"/> Tobacco |
| <input type="checkbox"/> Cocaine | <input type="checkbox"/> Marijuana | <input type="checkbox"/> Other _____ |

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature: _____

Date: _____