Nephrology Associates of Syracuse, P.C.

Date_____

List all surgeries with dates

Patient History Form

_____

_____

_____

_____

_____

Name _____

Date of Birth_____ Age _____

Primary Care Physician _____

Which doctor referred you? _____

Patient Email Address _____

Please List Other Physicians You Are Seeing:

_____

_____

Current Medications (include over-the-counter medicines like Tylenol, Advil, Motrin, Aleve, vitamins, supplements, etc.)

Medication Name/Dosage/Reason for Taking

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Medical History (check all that apply)

☐ High blood pressure	☐ High cholesterol	☐ Stroke	☐ Depression
☐ Diabetes	☐ Asthma	☐ Neuropathy	☐ Arthritis
☐ Leg swelling	☐ COPD	☐ Anemia	☐ Spine disease
☐ Kidney stones	☐ GERD	☐ Ulcers	☐ Osteoporosis
☐ Heart disease	☐ Sleep apnea	☐ GI bleeding	☐ Frequent UTI
☐ Heart failure	☐ Allergies	☐ Hepatitis	☐ Irregular heart
☐ Heart valve problem	☐ Gout	☐ Gallbladder	☐ Seizures
☐ Heart murmur	☐ Vascular disease	☐ Cancer	☐ Thyroid

Other: _____

_____

Allergies _____

Social History (check all that apply)

Occupation_____ ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Smoker? ☐ Yes ☐ No If yes, for how long? _____ # packs/day_____

Alcohol Use? ☐ Yes ☐ No If yes, how much? _____ Drug Use? ☐ Yes ☐ No

Immunizations (check all that apply and include date)

☐ Pneumovax Date _____ ☐ Flu Vaccine Date _____

Preventive Screening (check box if yes, and include date)

☐ Colonoscopy Date _____

Family Medical History (check all that apply)

Relative	Living	Deceased	Kidney Disease/ Dialysis	High Blood Pressure	Heart Disease	Diabetes	Cancer	Unknown
Mother	☐	☐	☐	☐	☐	☐	☐	☐
Father	☐	☐	☐	☐	☐	☐	☐	☐
Siblings	☐	☐	☐	☐	☐	☐	☐	☐
Son	☐	☐	☐	☐	☐	☐	☐	☐
Daughter	☐	☐	☐	☐	☐	☐	☐	☐

Please note any additional family medical history. _____

_____

Review of Systems (Please indicate any personal history within the last three months)

General
- ☐ Chills
- ☐ Fever
- ☐ Night sweats
- ☐ Poor appetite
- ☐ Weight loss
- ☐ Weight gain
- ☐ Loss of energy

Eyes
- ☐ Sudden vision changes
- ☐ Double vision

Ears
- ☐ Sudden loss of hearing
- ☐ Ringing in the ears
- ☐ Frequent ear infections

Nose
- ☐ Nasal congestion
- ☐ Frequent sinus infection
- ☐ Frequent nose bleeds

Mouth/Throat
- ☐ Frequent throat infections
- ☐ Change in voice

Lungs
- ☐ Chronic cough
- ☐ Coughing up blood
- ☐ Shortness of breath with activity

Heart
- ☐ Chest pain or pressure
- ☐ Heart palpitations
- ☐ Irregular heart beat
- ☐ Waking up short of breath
- ☐ Use many pillows to sleep
- ☐ Swelling: legs/ankles/feet
- ☐ Calf pain when walking

Stomach/Intestines
- ☐ Difficult swallowing
- ☐ Heartburn/indigestion
- ☐ Stomach pain/discomfort
- ☐ Nausea or vomiting
- ☐ Vomiting blood
- ☐ Blood in stools
- ☐ Constipation
- ☐ Chronic diarrhea
- ☐ Do you use laxatives?
- ☐ Black, tarry stools
- ☐ History of jaundice

Endocrine
- ☐ Excessive thirst
- ☐ Cold/heat intolerance
- ☐ Hot flashes

Genitourinary
- ☐ Prostate problems
- ☐ Weak/slow urine stream
- ☐ Kidney stones
- ☐ Frequent urination
- ☐ Blood in urine
- ☐ Burning with urination
- ☐ Wake at night to urinate

Nervous System
- ☐ Severe headaches
- ☐ Dizziness/lightheadedness
- ☐ Loss of balance
- ☐ Numbness or tingling

Bones/Muscles/Joints
- ☐ Painful joints
- ☐ Swelling of joints

Skin
- ☐ Skin rash
- ☐ Easy bruising

Blood
- ☐ Anemia
- ☐ Blood loss
- ☐ Blood transfusion

Psychiatric
- ☐ Mood swings
- ☐ Depression
- ☐ Anxiety
- ☐ Sleep problems

Other Issues (please list)