Nephrology Associates
of North Central Florida, P.A.

Medical and Personal History Form

Date:___________________

Please Bring All of your Current Medications in a Bag to Your First Appointment

Name:____ Date of Birth:_____________

Referred by Dr.________________________________

Primary Care Physician (if different from referral doctor): ______________________________

Why were you sent to see a kidney doctor?____
____
____

Medical History:

- ☐ Kidney disease
  - ☐ CKD Stage: 1 2 3 4 5
  - ☐ Transplant
  - ☐ Dialysis
  - ☐ Polycystic kidney disease
  - ☐ Acute kidney injury
  - ☐ Glomerulonephritis
- ☐ Diabetes
  - Type: ___ Type I
  - ___ Type II
- ☐ High blood pressure
  - Type ___ Essential
  - ___ Renovascular
- ☐ Ischemic Heart disease
  - ☐ Heart attack
  - ☐ Angina
  - ☐ Angioplasty
  - ☐ Coronary stent
  - ☐ CABG
- ☐ Cancer
  - ☐ Lung
  - ☐ Breast
  - ☐ Colon
  - ☐ Melanoma
  - ☐ Bladder
  - ☐ Lymphoma
  - ☐ Kidney
  - ☐ Thyroid
  - ☐ Leukemia
  - ☐ Endometrial
  - ☐ Pancreatic
- ☐ Stroke
- ☐ Gout

EENT

- ☐ Blindness
- ☐ Cataracts
- ☐ Hearing problems
- ☐ Glaucoma

Cardiovascular

- ☐ Atrial fibrillation
- ☐ Pacemaker
- ☐ High Cholesterol
- ☐ AICD
- ☐ Valvular Heart disease
- ☐ Congestive heart failure
- ☐ Mitral valve prolapse

Respiratory

- ☐ COPD
- ☐ Chronic bronchitis
- ☐ Asthma
- ☐ Emphysema
- ☐ Pneumonia
- ☐ Tuberculosis
- ☐ Sleep apnea

Gastrointestinal

- ☐ GERD
- ☐ Stomach/Bowel ulcers
- ☐ Gall bladder disease
- ☐ Hepatitis
- ☐ Inflammatory bowel disease
- ☐ Irritable bowel syndrome
- ☐ Gluten intolerance
- ☐ Lactose intolerance

Genitourinary

- ☐ Kidney stones
- ☐ Frequent UTIs

OB History

- ☐ Preeclampsia
- ☐ Pregnancy induced htn
- ☐ Gestational diabetes
- ☐ History of complicated pregnancy

Musculoskeletal

- ☐ Osteoarthritis
- ☐ Osteoporosis

Neurological

- ☐ Multiple sclerosis
- ☐ Seizures
- ☐ Parkinson’s
- ☐ Dementia

Psychiatric

- ☐ Depression
- ☐ Anxiety disorder

Endocrine

- ☐ Hypothyroidism
- ☐ Hyperparathyroidism
  - ☐ Primary
  - ☐ Secondary
- ☐ Hyperthyroidism
- ☐ Adrenal insufficiency

Hematology

- ☐ Anemia
- ☐ Sickle cell disease
- ☐ Sickle cell trait
- ☐ Blood transfusion
- ☐ Thalassemia

Immuno/Allergy

- ☐ HIV
- ☐ AIDS
- ☐ Rheumatoid arthritis
- ☐ Lupus

Other

- ☐ Obesity
- ☐ PAD
- ☐ Vitamin D deficiency
- ☐ MGUS
- ☐ Monoclonal gammopathy
- ☐ Hypo ☐ Hyper Natremia
- ☐ Hypo ☐ Hyper Calcemia
- ☐ Hypo ☐ Hyper Kalemia
- ☐ Hypo ☐ Hyper Magnesemia
- ☐ Metabolic acidosis

Other Medical Problems:

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________
6. ______________________________

Surgical History

- ☐ Appendectomy
- ☐ CABG
- ☐ Carotid endarterectomy
- ☐ Cataract surgery
- ☐ D & C
- ☐ Gallbladder removal
- ☐ Gastric bypass
- ☐ Hemorrhoidectomy
- ☐ Hernia repair
- ☐ Hip replacement
- ☐ Knee replacement
- ☐ Hysterectomy
- ☐ Nephrectomy
- ☐ Renal transplant
- ☐ Thyroidectomy
- ☐ Tonsillectomy
- ☐ Valve replacement
- ☐ AV fistula
- ☐ AV graft
- ☐ PD catheter

OTHER SURGERIES:

1. _______________________Date:________
2. _______________________Date:________
3. _______________________Date:________
4. _______________________Date:________
5. _______________________Date:________
6. _______________________Date:________
7. _______________________Date:________
8. _______________________Date:________

Family History

Illnesses

Illness		
Kidney Disease ☐ None	☐ Father ☐ Mother	☐ Sibling ☐ Child
Diabetes ☐ None	☐ Father ☐ Mother	☐ Sibling ☐ Child
High Blood Pressure ☐ None	☐ Father ☐ Mother	☐ Sibling ☐ Child
Ischemic Heart Disease ☐ None	☐ Father ☐ Mother	☐ Sibling ☐ Child
Cancer ☐ None	☐ Father ☐ Mother	☐ Sibling ☐ Child
Stroke ☐ None	☐ Father ☐ Mother	☐ Sibling ☐ Child
Gout ☐ None	☐ Father ☐ Mother	☐ Sibling ☐ Child
ADPKD ☐ None	☐ Father ☐ Mother	☐ Sibling ☐ Child
Dementia ☐ None	☐ Father ☐ Mother	☐ Sibling ☐ Child

Status

Father Living Deceased Unknown

If Deceased, Age: ______ Cause of Death:______________

Mother Living Deceased Unknown

If deceased, Age: ______ Cause of Death:______________

Social History

General

Current Marital Status	☐ Married ☐ Separated	☐ Single ☐ Widowed	☐ Divorced
Living Arrangement	☐ Alone ☐ Family member	☐ Spouse ☐ In home caregiver	☐ Significant other ☐ Assisted living facility
Occupation	☐ Retired ☐ Unemployed	☐ Employed ☐ Student	
Functional/Cognitive	☐ No impairment ☐ Hearing loss ☐ Limited mobility	☐ Memory deficit ☐ Poor vision or blind ☐ Transportation challenges	

Habits

Tobacco Use	☐ Current user	☐ Former user	☐ Never used
○ Cigarettes ○ Pipes ○ Cigars ○ Chewing ○ Snuff	Year Started ______	Year Quit _______	
Alcohol Use	☐ Current user	☐ Former user	☐ Never used
	o Occasional/social	o 1-2 drinks/day	o >3 drinks/day
Recreational Drug Use	☐ Current user	☐ Former user	☐ Never used
o Marijuana o Amphetamines o LSD	o Heroin o Ecstasy o Opium	o Cocaine o Barbiturates o Other	

Advanced Care Plan:

1. Do you have an advanced care plan? Yes or No
   If yes, please state the relationship of the person named as the decision maker

   Example : Spouse, Son, Friend, or other

   Decision maker: ___________________

Immunizations:

1. Have you received the flu shot? Yes or No
   Date of last flu shot: ______________ Example Sept 2017

2. Have you received the pneumonia shot? Yes or No
   Date of last pneumonia shot: ______________ Example Sept 2017

Pharmacy Name and address: ____

____

Drug Allergies: □ **No Known Drug Allergies**

1. ______________________ Reaction:_________
2. ______________________ Reaction:_________
3. ______________________ Reaction:_________
4. ______________________ Reaction:_________
5. ______________________ Reaction:_________
6. ______________________ Reaction:_________
7. ______________________ Reaction:_________
8. ______________________ Reaction:_________
9. ______________________ Reaction:_________
10. ______________________ Reaction:_________

Medications: Please list ALL medications including prescription, over the counter, vitamins and supplements in the table on the next page.

Medication Name	Dosage	Number of pills	How often
Example: Furosemide	20mg	1 tablet	One time a day