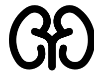

Advanced Kidney Care of North Texas

Patient Health History

Please complete this form in its entirety.

Name: ____ Date of birth: ______/_______/_______

Home Phone #: ________-___________-______________ Cell phone #: _________-__________-_____________

Preferred phone (Home/Cell): ______________________________Email: ______________________________________

Local pharmacy: Phone # _______-________-_____________ Name & location: _________________________________

Mail-order pharmacy: Phone # _______-________-___________ Name & location: ______________________________

Current Providers: Circle (or write) specialty and provide the provider's name, address, and phone number.

Specialty	Provider Name	Address & Phone Number
Primary care doctor/Internist		
Heart doctor/Cardiologist		
Diabetes doctor/Endocrinologist		
Hematologist/Oncologist		
Rheumatologist		
Urologist		
Other:		
Other:		

Medical History: Circle yes/no and provide additional medical conditions if applicable.

High blood pressure:	**Yes or No**	**Stroke/TIA**:	**Yes or No**
Diabetes:	**Yes or No**	**Kidney stones**:	**Yes or No**
Chronic kidney disease:	**Yes or No**	**Congestive heart failure:**	**Yes or No**
Heart disease:	**Yes or No**	**Heart attack**:	**Yes or No**
List any other medical conditions:			

Do you use any of the following? (Please Circle): Tylenol Motrin ibuprofen Aleve acetaminophen naproxen

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Drug allergies:____ ___OR - No known drug allergies

Medications: Please provide medication name, dose, frequency, and time taken.

Medication	Dose/Strength (Mg, etc.)	Frequency & Time Taken (AM/PM)

Social History: Fill in or circle correct answer.

Do you smoke? **Yes** **No** If yes, what type: ___________Number of years:_________Quit (year): ____________

Do you live: **Alone** OR - with others (who?) ___________________________

Current occupation:___________________OR - Retired

Do you drink alcohol? **Yes** **No** If yes, what type: _________Number of years:____________Quit (year) __________

Number of drinks/weeks: ____________

Illicit/Recreational drug use: **Yes** **No**

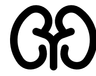
Family History: Please list any medical issues. Do not include name of mother/father.

Mother (List any medical problems): ____ Deceased age: _______

Father (List any medical problems): ____ Deceased age: _______

Family history of the following: (please indicate which relative)

Kidney Disease:	**Yes or No**	**Hypertension:**	**Yes or No**
Cancer:	**Yes or No**	**Coronary Artery Disease:**	**Yes or No**



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Vaccine History: Please list any recent vaccines and dates received.

Vaccination Name	Date Received

Surgical History: List any surgeries/major procedures and the date it occurred.

Surgery/Procedure Name	Date

Current symptoms: Please check any problems below that you experience currently.

☐ Fever/chills	☐ Persistent Cough	☐ Diarrhea	☐ Frequent Urination	☐ Straining to Urinate	☐ Bone or Joint Pain
☐ Night Sweats	☐ Wheezing	☐ Blood in Urine	☐ Up at night to urinate often	☐ Excess Urination	☐ Headaches
☐ Blurry Vision	☐ Nausea	☐ Kidney Stones	☐ Foamy Urine	☐ Leaky Bladder	☐ Dizziness or Vertigo
☐ Nosebleeds	☐ Vomiting	☐ Burning with Urination	☐ Weak Urine Stream	☐ Muscle pain or weakness	☐ Balance Problems
☐ Sinus Problems	☐ Irregular Heart Rate	☐ Swelling in hands or feet	☐ Shortness of breath	☐ Leg pain or cramps	☐ Constipation
☐ Chest Pain	☐ Abdominal Pain	☐ Confusion	☐ Excessive Thirst	☐ Chronic Fatigue	☐ Back Pain