Central Coast Renal Care

Patient History Form

Complete this form in its entirety and to the best of your ability.

PERSONAL HISTORY

Please provide the following information regarding YOUR past social history:

Name: _____ **Birthdate:** _____/_____/_____
First MI Last Suffix

Marital Status: Single Married Separated Divorced Widowed

Current Occupation: _____ **Previous Occupation:** _____

With whom do you live?: _____

Do you smoke?: YES I QUIT NEVER

If Yes, for how long_____

If you quit, when? _____

Do you drink alcohol?: YES I QUIT NEVER

If Yes, for how long_____

If you quit, when? _____

MEDICAL HISTORY

Please provide the following information regarding YOUR past medical history:

Have you recently, or are you currently experiencing any of the following symptoms:

Blood in the urine (Hematuria)	**YES**	**NO**	Protein in the urine	**YES**	**NO**
Foamy urine	**YES**	**NO**	Frequent urination	**YES**	**NO**
Waking to urinate	**YES**	**NO**	Bedwetting	**YES**	**NO**
Incontinence	**YES**	**NO**	Pain on urination	**YES**	**NO**
Urinary infection (UTI)	**YES**	**NO**	Low Urine Output	**YES**	**NO**
Prostate problems	**YES**	**NO**	Kidney stones	**YES**	**NO**
Chronic Kidney Disease	**YES**	**NO**	Needed Dialysis	**YES**	**NO**

Please check any of the following illnesses that you have, or have had in the past:

____ Heart Disease	____ Heart Failure	____ Heart Valve Problem
____ Heart Murmur	____ High Blood Pressure	____ High Cholesterol
____ Seizures	____ Stroke	____ Nerve Damage/Neuropathy
____ Diabetes Mellitus	____ Bleeding Problems	____ Anemia
____ Asthma	____ COPD	____ Sleep Apnea
____ Tuberculosis	____ GI Bleeding	____ Gout
____ Gallbladder	____ GERD	____ Ulcers
____ Arthritis	____ Spine Disease	____ Thyroid Disease
____ Depression	____ Anxiety	____ Vision Problems
____ Hearing Loss	____ Cancer (if yes, indicate location) _____	

Please explain any treatments, including dates, along with any questions or concerns you have regarding the issues marked above: _____

_____

_____

FAMILY HISTORY

Please provide the following information regarding YOUR FAMILY'S past medical history:

Please mark any of the following which your family members have/have had & who:

____ **Heart Disease** _____

____ **High Blood Pressure** _____

____ **Diabetes** _____

____ **Kidney Disease** _____

____ **Stroke** _____

____ **Cancer** _____

____ **Blindness** _____

____ **Deafness** _____

____ **Other** _____

_____

ACKNOWLEDGEMENT OF CARE

Who is your Primary Care Physician?: _____

Is this who referred you to our office:? YES NO, who: _____

What is the reason you were referred to a kidney specialist?: _____

_____

How long have you been aware of this health issue?: _____

Have you seen any other physicians for this issue:? YES NO I'M NOT SURE

If Yes, whom did you see?: _____ **When?:** _____

Have you had any imaging (ultrasound, etc.) of your kidneys? YES NO I'M NOT SURE

If Yes, where?: _____ **When?:** _____

Please list any additional questions or concerns you would like the physician to address with you during your visit: _____

_____

_____

_____

ONCE ALL FORMS HAVE BEEN COMPLETED, PLEASE RETURN TO THE RECEPTIONIST.

THANK YOU