RenalCare Associates, S.C.
Patient History Form

General Information

Name: ______________________________ Date: ______________

Name you prefer to be called: ______________ Date of Birth: ____________

Race: ☐ African-American ☐ Hispanic ☐ Other:__________
☐ Asian ☐ Indian
☐ Caucasian ☐ Pacific Islander

Previous Hospitalizations/Surgeries (use back if necessary)

Month/Year	Hospital	Reason

Medical Illnesses

Diabetes	Yes/No
High Blood Pressure	Yes/No
Cancer	Yes/No
Stroke	Yes/No
Heart Trouble	Yes/No
Arthritis/Gout	Yes/No
Convulsions/Seizures	Yes/No
On-going Infection	Yes/No
Hereditary Diseases	Yes/No
Emphysema	Yes/No

Allergies Please list any medicines you are allergic to and the reaction you had (e.g. hives, nausea, etc.)

1. ______________________________
2. ______________________________

Immunizations

Date of last flu vaccine ______________

Date of last pneumovax vaccine ______________

Medications Please list the dose and frequency of **all** medications you take including over the counter medications (e.g., aspirin, antacids, vitamins, etc.)

1. ______________ 6. ______________
2. ______________ 7. ______________
3. ______________ 8. ______________
4. ______________ 9. ______________
5. ______________ 10. ______________

Social History (circle any that apply)

Marital Status: ☐ single ☐ married ☐ separated ☐ divorced ☐ widowed

Occupation ______________________ Any exposure to toxins/solvents/leads? ________

Have you used: ☐ cigarettes ☐ cigars ☐ pipe ☐ chewing tobacco

How much/often ______________ Quit?: ☐Yes ☐No When ______________

Do you use alcohol? ☐Yes ☐No If yes, how much/often? ______________

Family Member	Age	Health Problems	If deceased, give age and cause of death
Mother	____	____________	____________
Father	____	____________	____________
Siblings	____	____________	____________
	____	____________	____________
Children	____	____________	____________
	____	____________	____________

System Review (please ask the doctor if you do not understand any of these terms)

Constitutional Symptoms

Good general health lately	No	Yes
Recent weight change	No	Yes
Fever	No	Yes
Fatigue	No	Yes

Eyes

Eye disease or injury	No	Yes
Wear glasses/contact lenses	No	Yes
Blurred or double vision	No	Yes
Glaucoma	No	Yes

Ears/Nose/Mouth/Throat

Hearing loss or ringing	No	Yes
Earaches or drainage	No	Yes
Chronic sinus problems	No	Yes
Nosebleeds	No	Yes
Mouth sores	No	Yes
Bleeding gums	No	Yes
Bad breath or bad taste	No	Yes
Sore throat or voice change	No	Yes

Cardiovascular

Heart trouble	No	Yes
Chest pain	No	Yes
Palpitations	No	Yes
Swelling of feet, ankles, or hands	No	Yes
High blood pressure	No	Yes

Respiratory

Chronic or frequent cough	No	Yes
Spitting up blood	No	Yes
Shortness of breath with exertion	No	Yes
Shortness of breath lying flat	No	Yes
Asthma or wheezing	No	Yes

Gastrointestinal

Loss of appetite	No	Yes
Change in bowel movements	No	Yes
Nausea or vomiting	No	Yes
Frequent diarrhea	No	Yes
Constipation	No	Yes
Painful bowel movements	No	Yes
Rectal bleeding or blood in stool	No	Yes
Black colored stools	No	Yes
Abdominal pain or heartburn	No	Yes

Musculoskeletal

Joint pain	No	Yes
Joint stiffness or swelling	No	Yes
Weakness of muscles	No	Yes
Back pain	No	Yes
Difficulty in walking	No	Yes

Genitourinary

Frequent urination	No	Yes
Burning or painful urination	No	Yes
Blood in urine	No	Yes
Diminished stream in urination	No	Yes
Incontinence or dribbling	No	Yes
Kidney stones	No	Yes
Sexual difficulty	No	Yes
Male – testicle pain	No	Yes
Female – pain with periods	No	Yes
Female – irregular periods	No	Yes
Female – vaginal discharge	No	Yes

Female – Date of last period ____________

Female – Date of last pap smear ____________

Female - # pregnancies_____ Miscarriages_____

Integument

Rash	No	Yes
Itching	No	Yes
Change in skin color or texture	No	Yes
Change in hair or nails	No	Yes
Breast pain	No	Yes
Breast lump	No	Yes
Breast discharge	No	Yes

Females – Date of last mammogram __________

Neurologic

Frequent or recurring headaches	No	Yes
Lightheaded or dizzy	No	Yes
Convulsions or seizures	No	Yes
Numbness or tingling sensations	No	Yes
Tremors	No	Yes
Paralysis	No	Yes
Stroke	No	Yes
Head injury	No	Yes

Psychiatric

Memory loss or confusion	No	Yes
Nervousness	No	Yes
Depression	No	Yes
Insomnia	No	Yes

Endocrine

Thyroid disease	No	Yes
Diabetes	No	Yes
Heat or cold intolerance	No	Yes
Change in hat or glove size	No	Yes

Hematologic/Lymphatic

Bleeding or bruising tendency	No	Yes
Anemia	No	Yes
Past transfusion	No	Yes
Enlarged glands (neck/armpit/groin)	No	Yes