TIDEWATER KIDNEY SPECIALISTS, INC.

BOARD CERTIFIED IN INTERNAL MEDICINE AND NEPHROLOGY
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Visit us at www.tksva.com

(Confidential Record: Information contained here will not be released unless you have authorized us to do so.)

LAST NAME	FIRST	MIDDLE	D.O.B.	BIRTHPLACE
ADDRESS	CITY	STATE ZIP	TELEPHONE	BUS. PHONE
OCCUPATION		SOCIAL SECURITY NO.	CELL PHONE	(CIRCLE ONE) MALE FEMALE
EMAIL ADDRESS			OTHER PHONE	
INSURANCE COMPANY		INSURANCE NO.	MARITAL STATUS (CIRCLE ONE) SINGLE MARRIED WIDOWED DIVORCED SEPARATED	RELIGION
2nd INSURANCE COMPANY		INSURANCE NO.		RACE
				LANGUAGE
PHARMACY	LOCATION	PHONE NO.		

FAMILY HISTORY (NAMES PLEASE)	SEX	AGE	HEALTH	AGE AT DEATH	CAUSE OF DEATH
MOTHER					
FATHER					
SIBLINGS					
CHILDREN					
(If additional room is needed, please use back of page.)					

MEDICATIONS AND SUPPLEMENTS (vitamins, aspirin, etc.)

(Please list dosages)

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ALLERGIES: _____

_____

PAST MEDICAL HISTORY: (surgeries, hospitalizations, procedures, chronic illness, problems under control and the date of diagnosis)

_____

_____

_____

_____

_____

_____

_____

_____

_____

PERSONAL HABITS: (Circle Yes or No)

Do you or have you ever regularly smoked? (Yes No) Cigarettes ___ Pipe ___ Cigars ___ For how many years? _____

Do you usually drink over 6 cups of coffer per day? (Yes No)

Do you regularly drink alcohol? (Yes No) Ounces per day _____ Beer – Bottles/cans per day _____

Have you ever used illicit drugs? (Yes No) What type? _____How often?_____

GENERAL:

Yes	No	Do you have difficulty falling asleep?
Yes	No	Do you awaken early in the morning with apparent cause?
Yes	No	Do you have depression or mood fluctuations?

10 System Review

NEUROLOGICAL:

Yes	No	Do you frequently have severe headaches? (If no, please skip to the next set of questions. If yes, please answer the following.)
Yes	No	Do they cause visual trouble?
Yes	No	Do they occur on one side of the head?
Yes	No	Do they awaken you at night from sleep?
Yes	No	Do they feel like a tight band?
Yes	No	Do they hurt most in the back of the head and neck?
Yes	No	Does aspirin relieve them?
Yes	No	Spells of dizziness?
Yes	No	Spells of weakness of arms or legs?
Yes	No	Have you ever had a convulsion?
Yes	No	Double vision?

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HEENT:

Yes No Ringing in ears?
Yes No Pain in ears?
Yes No Nose bleeds?

HEENT CONT:

Yes No Have you had swollen lymph nodes?
Yes No Do you frequently have bleeding gums?
Yes No Do you frequently have trouble swallowing?
Yes No Do you frequently have hoarseness?
Yes No Do you frequently have a sore tongue?
Yes No Problem with eyes, ears, nose and throat? Please explain:_____

PULMONARY:

HAVE YOU EVER HAD SHORTNESS OF BREATH (Circle)

Yes No Doing your usual work?
Yes No Climbing a flight of stairs?
Yes No That awakens you at night?
Yes No That causes you to cough?
Yes No Accompanied by wheezing?
Yes No Do you have a chronic cough?
Yes No Have you ever coughed up blood?
Yes No Do you cough up much sputum?

CARDIAC:

HAVE YOU EVER HAD CHEST PAIN OR TIGHTNESS IN THE CHEST (Circle)

Yes No When exerting yourself?
Yes No When walking against the wind?
Yes No When walking up a hill?
Yes No When walking fast?
Yes No When walking in cold weather?
Yes No After a heavy meal?
Yes No When upset or excited?
Yes No Have you ever fainted?
Yes No With palpitations?
Yes No With radiation down the arm?
Yes No That disappears if you rest?
Yes No That only occurs at rest?
Yes No Do you sleep on more than one pillow?

If you have chest pain or tightness, please explain_____

MUSCULOSKELETAL:

Yes No Do you have pains in calves or legs when walking?
Yes No Do you have cramps in legs at night?
Yes No Do you have varicose veins?
Yes No Do you have phlebitis or inflamed leg veins?
Yes No Do you have swelling in the ankles?

Do you or have you ever had: (circle all that apply)

Joint Pains Neck Pain Back Pain Gout

Other chronic pains?_____

If "YES" what medications have you taken for this now and in the past:_____

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GASTROINTESTINAL:

Do you have any of the following:

Yes No Nausea
Yes No Vomiting
Yes No Constipation
Yes No Abdominal Pains

If "YES" Please give a brief description:_____

_____

_____

_____

_____

_____

SKIN:

Do you have or have had a rash or skin condition?

If "YES" please give a brief description:_____

_____

_____

_____

HEMATOLOGIC:

Do you bruise or bleed easily?

If "YES" please give a brief description:_____

_____

_____

_____

URINARY:

HAVE YOU HAD (Circle)

Yes No Burning when urinating?
Yes No Loss of control of bladder?
Yes No Blood in the urine?
Yes No Dark colored urine?
Yes No Trouble starting to urinate?
Yes No Trouble holding the urine?
Yes No Frequency of urination at night?
Yes No Passing of a kidney stone?

GYNECOLOGICAL/GENITALS:

Yes No Are you still having regular monthly periods?
Yes No Have you ever had a miscarriage? When? _____
Date of last menstrual period _____ Date periods first started _____
How many children born alive? _____ How many stillbirths? _____
How many premature births? _____ How many miscarriages? _____
How many Cesarean operations? _____ Any complications of pregnancy? Yes No
Describe _____

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GYNECOLOGICAL/GENITALS CONT:

Yes No Loss of sexual activity? For how long? _____
Yes No Hernia (rupture)? _____
Yes No Prostate trouble? _____

RELATIVES WHO HAVE OR HAD THE FOLLOWING:

(Please circle and give relationship)

Stroke _____
Cancer _____
Hypertension _____
Tuberculosis _____
Diabetes _____
Leukemia _____
Epilepsy _____
Suicide _____
Migraine _____
Asthma _____
Hay Fever _____
Bleeding tendency_____
Heart attack _____
Stomach ulcers _____
Kidney disease _____
Goiter _____
Arthritis _____
Colitis _____
Nervous breakdown _____
Rheumatic heart _____
Insanity _____
Congenital heart _____

BRIEFLY DESCRIBE YOUR PRESENT MEDICAL SYMPTOMS

_____
_____
_____
_____
_____
_____
_____
_____
_____

_____ _____
Signed Date