



NEPHROLOGY

ASSOCIATES OF SYRACUSE, P.C.

Date _____

List all surgeries with dates

Patient History Form

Name _____

Date of Birth _____ Age _____

Primary Care Physician _____

Which doctor referred you? _____

Patient Email Address _____

Please List Other Physicians You Are Seeing:

Current Medications (include over-the-counter medicines like Tylenol, Advil, Motrin, Aleve, vitamins, supplements, etc.)

Medication Name/Dosage/Reason for Taking

Medical History (check all that apply)

- | | | | |
|--|---|--------------------------------------|--|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Stroke | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Asthma | <input type="checkbox"/> Neuropathy | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Leg swelling | <input type="checkbox"/> COPD | <input type="checkbox"/> Anemia | <input type="checkbox"/> Spine disease |
| <input type="checkbox"/> Kidney stones | <input type="checkbox"/> GERD | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Sleep apnea | <input type="checkbox"/> GI bleeding | <input type="checkbox"/> Frequent UTI |
| <input type="checkbox"/> Heart failure | <input type="checkbox"/> Allergies | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Irregular heart |
| <input type="checkbox"/> Heart valve problem | <input type="checkbox"/> Gout | <input type="checkbox"/> Gallbladder | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Vascular disease | <input type="checkbox"/> Cancer | <input type="checkbox"/> Thyroid |

Other: _____

Allergies _____

Social History (check all that apply)

Occupation _____ Single Married Divorced Widowed

Smoker? Yes No If yes, for how long? _____ # packs/day _____

Alcohol Use? Yes No If yes, how much? _____ Drug Use? Yes No

Immunizations (check all that apply and include date)

Pneumovax Date _____ Flu Vaccine Date _____

Preventive Screening (check box if yes, and include date)

Colonoscopy Date _____

Family Medical History (check all that apply)

Relative	Living	Deceased	Kidney Disease/ Dialysis	High Blood Pressure	Heart Disease	Diabetes	Cancer	Unknown
Mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Siblings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Son	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Daughter	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please note any additional family medical history. _____

Review of Systems (Please indicate any personal history within the last three months)

General

- Chills
- Fever
- Night sweats
- Poor appetite
- Weight loss
- Weight gain
- Loss of energy

Eyes

- Sudden vision changes
- Double vision

Ears

- Sudden loss of hearing
- Ringing in the ears
- Frequent ear infections

Nose

- Nasal congestion
- Frequent sinus infection
- Frequent nose bleeds

Mouth/Throat

- Frequent throat infections
- Change in voice

Lungs

- Chronic cough
- Coughing up blood
- Shortness of breath with activity

Heart

- Chest pain or pressure
- Heart palpitations

- Irregular heart beat
- Waking up short of breath
- Use many pillows to sleep
- Swelling: legs/ankles/feet
- Calf pain when walking

Stomach/Intestines

- Difficult swallowing
- Heartburn/indigestion
- Stomach pain/discomfort
- Nausea or vomiting
- Vomiting blood
- Blood in stools
- Constipation
- Chronic diarrhea
- Do you use laxatives?
- Black, tarry stools
- History of jaundice

Endocrine

- Excessive thirst
- Cold/heat intolerance
- Hot flashes

Genitourinary

- Prostate problems
- Weak/slow urine stream
- Kidney stones
- Frequent urination
- Blood in urine

- Burning with urination
- Wake at night to urinate

Nervous System

- Severe headaches
- Dizziness/lightheadedness
- Loss of balance
- Numbness or tingling

Bones/Muscles/Joints

- Painful joints
- Swelling of joints

Other Issues: (please list)

Skin

- Skin rash
- Easy bruising

Blood

- Anemia
- Blood loss
- Blood transfusion

Psychiatric

- Mood swings
- Depression
- Anxiety
- Sleep problems

Patient Name & DOB:
