TAMPA BAY NEPHROLOGY ASSOCIATES, P.L.

NEW PATIENT HEALTH HISTORY QUESTIONNAIRE (DATE: _____)

Name *(Last, First, M.I.):*		☐ M ☐ F	**DOB:**
Marital status:	☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed		
Referring physician:		**Date of last physical exam:**	
Other physicians you see:			
Do you give us permission to discuss your care with a family member or spouse? **If so, please list their name & relationship to you below:**			

PERSONAL HEALTH HISTORY

Childhood illness: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio ☐ Other

Immunizations and dates:	☐ Tetanus	☐ Pneumonia	☐ HPV
	☐ Hepatitis	☐ Chickenpox	☐
	☐ Influenza	☐ MMR *Measles, Mumps, Rubella*	☐

List any medical problems that other physicians have diagnosed (list below).

Surgeries

Year	Reason	Hospital

Other hospitalizations

Year	Reason	Hospital

Have you ever had a blood transfusion?	☐	Yes	☐	No
Have you ever had kidney failure?	☐	Yes	☐	No
Have you ever been on dialysis?	☐	Yes	☐	No
Have you ever had a kidney or other organ transplant? If so, When? Where?	☐	Yes	☐	No
Have you ever had blood in your urine?	☐	Yes	☐	No
Have you ever kidney stones?	☐	Yes	☐	No
Have you ever had gout?	☐	Yes	☐	No

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers		
Name the Drug	Strength	Frequency Taken

Allergies to Medications (Name of drug and reaction you had)

HEALTH HABITS AND PERSONAL SAFETY

Exercise	☐ Sedentary (No exercise)			☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)		
	☐ Occasional vigorous exercise (less than 4x/week for 30 min.)			☐ Regular vigorous exercise (4x/week for 30 minutes)		
Diet	Are you dieting?				☐ Yes	☐ No
	If yes, are you on a physician prescribed medical diet?				☐ Yes	☐ No
	# of meals you eat in an average day?					
	Rank salt intake	☐ High	☐ Med	☐ Low		
	Rank fat intake	☐ High	☐ Med	☐ Low		
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola	(#cups/cans per day)	
Alcohol	Do you drink alcohol?				☐ Yes	☐ No
	Are you concerned about the amount you drink?				☐ Yes	☐ No
	Have you considered stopping?				☐ Yes	☐ No
Tobacco	Do you use tobacco?				☐ Yes	☐ No
	☐ Cigarettes – #packs/day?		☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day	
	☐ # of years	☐ Or year quit				
Drugs	Do you currently use recreational or street drugs?				☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?				☐ Yes	☐ No
Sex	Are you sexually active?				☐ Yes	☐ No
	If yes, are you trying for a pregnancy?				☐ Yes	☐ No
	If not trying for a pregnancy, list contraceptive or barrier method used:					
	Do you/did you use intravenous drugs, or other illicit drugs or have unprotected sexual intercourse?				☐ Yes	☐ No
Personal Safety	Do you live alone?				☐ Yes	☐ No
	Do you have frequent falls?				☐ Yes	☐ No
	Do you have vision or hearing loss?				☐ Yes	☐ No
	Do you have an Advance Directive or Living Will?				☐ Yes	☐ No
	Do you use a walker or wheelchair at home?				☐ Yes	☐ No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**	☐ M ☐ F	
Mother				☐ M ☐ F	
Sibling	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**Grandmother** *Maternal*		
	☐ M ☐ F		**Grandfather** *Maternal*		
	☐ M ☐ F		**Grandmother** *Paternal*		
	☐ M ☐ F		**Grandfather** *Paternal*		

MENTAL HEALTH

Is stress a major problem for you?	☐	Yes	☐	No
Do you have problems with eating or your appetite?	☐	Yes	☐	No
Do you have trouble sleeping?	☐	Yes	☐	No

WOMEN ONLY

Date of last menses (period): Date of last PAP smear and rectal exam?				
Heavy periods, irregularity, spotting, pain, or discharge?	☐	Yes	☐	No
Number of pregnancies _____ Number of live births _____				
Are you pregnant or breastfeeding?	☐	Yes	☐	No
Have you had a D&C, hysterectomy, or Cesarean?	☐	Yes	☐	No
Any urinary tract, bladder, or kidney infections within the last year?	☐	Yes	☐	No
Any blood in your urine?	☐	Yes	☐	No
Any problems with control of urination?	☐	Yes	☐	No
Any hot flashes or sweating at night?	☐	Yes	☐	No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	☐	Yes	☐	No
Date of last mammogram and results?				

MEN ONLY

Do you usually get up to urinate during the night?	☐	Yes	☐	No
If yes, # of times _____				
Do you feel pain or burning with urination?	☐	Yes	☐	No
Any blood in your urine?	☐	Yes	☐	No
Do you feel burning discharge from penis?	☐	Yes	☐	No
Has the force of your urination decreased?	☐	Yes	☐	No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	☐	Yes	☐	No
Do you have any problems emptying your bladder completely?	☐	Yes	☐	No
Any difficulty with erection or ejaculation?	☐	Yes	☐	No
Any testicle pain or swelling?	☐	Yes	☐	No
Date of last prostate and rectal exam?	☐	Yes	☐	No

OTHER PROBLEMS

Check if you have presently, or in past had any symptoms in the following areas to a significant degree, please briefly explain.

☐ Skin	☐ Chest/Heart	☐ Recent changes in:
☐ Head/Neck	☐ Back	☐ Weight
☐ Ears	☐ Intestinal	☐ Energy level
☐ Nose	☐ Bladder	☐ Ability to sleep
☐ Throat	☐ Bowel	☐ Other pain/discomfort:
☐ Lungs	☐ Circulation	

Please give more information on above if indicated:

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