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:**					

PERSONAL HEALTH HISTORY

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

Covid 19 Illness:	Date of Test Positivity: _____ Date of Onset of Symptoms: _____ If Hospitalized Where: _____		Other Info:
Immunizations Vaccinations and dates:	☐ **Covid19 Vaccine** ☐ Yes or ☐ No Pfizer date (m/d/yr) 1st_____ 2nd _____ Booster _____ Moderna date (m/d/yr) 1st_____ 2nd _____ Booster _____ Johnson & Johnson date _____ Other (name/date) _____		☐ Influenza _____ ☐ Pneumonia_____ ☐ Shingles_____ ☐ HPV_____ ☐ Hepatitis A_____ ☐ Hepatitis B_____ ☐ MMR *Measles, Mumps, Rubella* _____ ☐ Tetanus (Tdap)
	☐ Other	☐ Other	☐ Other

List any medical problems that you have been diagnosed below:

Surgeries

Year	Reason	Hospital

Other hospitalizations (MI, Stroke, Covid, etc)

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 (USE BACK OF PAGE IF NEEDED)		
Name the Drug	Strength	Frequency Taken (daily, twice daily, three daily, prn)

Allergies to Medications (Name of drug and reaction/side effect)

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?				
Date of last colonoscopy 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
Date of last colonoscopy and results?				

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: