Hypertension and Kidney Care of North Atlanta, LLC

HEALTH HISTORY

NAME _____ AGE _____ WERE YOU REFERRED BY PHYSICIAN? ☐ YES ☐ NO

LIST ANY OTHER PHYSICIANS OR SPECIALISTS _____

REASON FOR SEEKING MEDICAL ATTENTION _____ RIGHT LEFT BOTH

DATE OF INJURY OR DURATION OF SYMPTOMS _____

HAVE YOU HAD ANY PROCEDURES: X-RAYS, ULTRA SOUND, EKG, BIOSPY, ETC...? FOR THIS CONDITION ? ☐ YES ☐ NO

IF YES, PLEASE LIST ORGANIZATION AND DATES: _____

HAVE YOU SEEN ANYONE FOR THIS CONDITION? ☐ YES ☐ NO

IF YES, PLEASE LIST NAMES AND DATES: _____

HAVE YOU EVER BEEN DIAGNOSED WITH ANY OF THE FOLLOWING CONDITIONS?

	YES	NO		YES	NO		YES	NO
ASTHMA	_____	_____	RHEUMATOID ARTHRITIS	____	____	OSTEOARTHRITIS	____	____
KINDNEY DISEASE	_____	_____	ANEMIA	____	____	ALCOHOLISM	____	____
LUPUS	_____	_____	MIRGRANES	____	____	SICK CELL DISEASE	____	____
BLEEDING TENDENCIES	_____	_____	CANCER	____	____	COLITIS	____	____
HEART DISEASE	_____	_____	DIABETES	____	____	STROKE	____	____
EPILEPSY	_____	_____	GOITER	____	____	STOMACH ULCERS	____	____
HIGH BLOOD PRESSURE	_____	_____	LUNG DISEASE	____	____	DEPRESSION/ANXIETY	____	____
POLIO	_____	_____	NERVOUS SYSTEM DISORDER	____	____	COPD (CHRONIC	____	____
HEPATITIS	_____	_____	TUBERCULOSIS	_____	____	OBSTRUCTIVE PULMONARY DISEASE)		
HIV	_____	_____	STD	_____	____	MENTAL ILLNESS	____	_____
ARE YOU ABLE TO PERFORM ACTIVITIES OF DAILY LIVING				_____	____			

OTHER MEDICAL CONDITIONS: _____

PLEASE LIST ANY SURGERIES AND DATES: _____

_____ _____

_____ _____

ARE YOU ALLERGIC TO: (CHECK IF YOU ARE)

LATEX ____ PENICILLIN ____ CEPHALOSPORIN ____ MYCINS ____ SULFA ___ TETANUS ____ IODINE ____
DYES ____ ASPIRIN ____ CODEINE ____ MORPHINE ____ ADHESIVE TAPE ____ ARTHRITIS MEDICINES _____

FOODS (PLEASE LIST): _____
OTHERS: _____
_____

DO YOU CURRENTLY USE TOBACCO: CIGARETTES ____ PIPE ____ SMOKELESS ____ AMOUT PER DAY: ____ QUIT WHEN? _____

DO YOU DRINK ALCOHOL: BEER ____ LIQUOR ____ WINE ____ AMOUNT PER DAY: _____ OR PER WEEK _____

HAS ANYONE IN YOUR FAMILY HAD?

KIDNEY DISEASE _____ HIGH BLOOD PRESSURE _____ HEART DISEASE _____ DIABETES _____ BLEEDING PROBLEMS _____

LUNG DISEASE _____ CANCER _____ WHAT TYPE OF CANCER? _____

HAVE YOU RECENTLY HAD ANY OF THE FOLLOWING PROBLEMS OR SYMPTOMS?

	YES	NO		YES	NO		YES	NO
CHEST PAIN	____	____	IRREGULAR HEART BEAT	____	____	FAINTING SPELLS	____	____
BREATHING DIFFICULTIES	____	____	COUGH	____	____	COUGH WITH BLOOD	____	____
NUMBNESS OR TINGLING	____	____	DIZZINESS	____	____	HEADACHES OR MIGRAINES	____	____
VISION CHANGES	____	____	FEVER OR CHILLIS	____	____	UNEXPECTED WEIGHT LOSS	____	____
ABDOMINAL PAIN	____	____	NAUSEA OR VOMITING	____	____	DIARRHEA	____	____
BLOODY OR BLACK TARRY STOOL	____	____	LOSS OF CONTROL OF BOWELS	____	____	DIFFICULTY STARTING URINE	____	____
PAIN OR BURNING ON URINATION	____	____	BLOOD IN URINE	____	____	LOSS OF CONTROL OF BLADDER	____	____

PATIENT'S SIGNATURE_____ PHYSICIAN'S SIGNATURE_____ DATE _____