Nephrology Associates
OF TIDEWATER, LTD.

Adult History and Review of Systems Questionnaire

Note: This is a confidential record of your medical history. As your doctors, it is important for us to know this information so we can provide you with the best healthcare possible. The information contained here will not be released to anyone without your prior consent.

Appointment Date: _____ **Appointment Time:** _____

Name: _____ **Date of Birth:** _____ **Gender:** _____

Have you ever seen a Nephrologist: ☐ Yes ☐ No

Social History:

Birthplace: _____ Marital Status: _____

Nationality: _____ Spouse\Significant Other: _____

Religion: _____ Your Occupation: _____

Drug Use: _____ Education: _____

Tobacco Use: ☐ Yes ☐ No If yes what type: _____ Previous Tobacco Use when did you quit: _____

Packs per day _____ for _____ years

Alcohol Use: _____ Drinks: _____ per ☐ Day ☐ Week ☐ Month

If heavy use how many years: _____ Quit: _____

Caffeine (coffee, tea, soda, chocolate) Servings per day _____

MEDICAL HISTORY: Have you ever had? (IF YES, CHECK APPROPRIATE BOXES)

☐ Cancer Type: _____

☐ Kidney Stones	☐ Stroke	☐ Asthma	☐ Thyroid Trouble
☐ Kidney Disease	☐ Gallstones	☐ Emphysema	☐ Hives
☐ Anemia	☐ Liver Disease	☐ Seizures	☐ Depression
☐ Diabetes	☐ Hepatitis/ Jaundice	☐ Osteoporosis	☐ Head Injury
☐ Heart Attack / Coronary	☐ Ulcer Disease	☐ Arthritis	☐ Broken Bones
☐ Artery Disease	☐ Heartburn/ Reflux	☐ Gout	☐ Blood Transfusions
☐ Heart Failure	☐ Pneumonia	☐ Frequent Bladder Infections	☐ Intravenous Drug Use
☐ High Blood Pressure	☐ Tuberculosis	☐ Frequent Sinus Infections	☐ Migraines
☐ High Cholesterol	☐ Positive TB Skin Test	☐ Glaucoma	☐ Prostate Enlargement

☐ Other _____

IMMUNIZATIONS (please provide date of last immunization)

☐ Influenza Vaccine Date: _____

☐ Pneumococcal Vaccine Date: _____

☐ Hepatitis B Vaccine Date: _____

PAST SURGICAL HISTORY: (if yes please check the box enter year)

☐ Eyes (laser or Vision Correction)	_____	☐ Gall Bladder	_____	☐ Spinal Surgery / Neck	_____
☐ Eyes (Contacts / Glaucoma)	_____	☐ Appendix	_____	☐ Spinal Surgery/ Back	_____
☐ Ears	_____	☐ Intestine / Colon	_____	☐ Orthopedic (Hip / Knee)	_____
☐ Sinus / Nasal Septum	_____	☐ Hemorrhoids	_____	☐ Shoulder/Feet/Hands	_____
☐ Tonsils / Adenoids	_____	☐ Hernia	_____	☐ C-Section	_____
☐ Thyroid	_____	☐ Breast	_____	☐ Vasectomy	_____
☐ Heart	_____	☐ Uterus / Hysterectomy	_____	☐ Tubal Ligation	_____
☐ Stomach	_____	☐ Ovaries	_____	☐ Transplant	_____
☐ Varicose Veins	_____	☐ Prostate	_____	Type of Transplant	_____

☐ Other _____

Do you CURRENTLY have? (IF YES, CHECK THE APPROPRIATE BOXES)

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GENERAL
- ☐ Fatigue
- ☐ Fever

SKIN
- ☐ Rash
- ☐ Skin Color Changes
- ☐ Bruising
- ☐ Itching
- ☐ Ulcers

HEENT
- ☐ Swelling Around the Eyes
- ☐ Oral Ulcers
- ☐ Sore Throat
- ☐ Dry Mouth
- ☐ Bad Taste in your Mouth

RESPIRATORY
- ☐ Cough
- ☐ Difficulty Breathing on Exertion
- ☐ Shortness of Breath
- ☐ Coughing up Blood

CARDIOVASCULAR
- ☐ Chest Pain
- ☐ Swelling of Extremities
- ☐ Palpitations
- ☐ Use of Extra Pillows When You Sleep
- ☐ Waking Up Because of Shortness of Breath

GASTROINTESTINAL
- ☐ Abdominal Pain
- ☐ Abdominal Swelling
- ☐ Constipation
- ☐ Diarrhea
- ☐ Blood in Stool
- ☐ Black Stool
- ☐ Nausea
- ☐ Vomiting
- ☐ Rectal Bleeding
- ☐ Trouble Swallowing

GENITOURINARY
- ☐ Change in Urinary Stream
- ☐ Frequency
- ☐ Blood in Urine
- ☐ Difficulty Emptying Bladder
- ☐ Pain with urination
- ☐ Urination at Night
- ☐ Hesitancy
- ☐ Urgency

MUSCULOSKELETAL
- ☐ Joint Redness
- ☐ Joint Swelling
- ☐ Joint Stiffness
- ☐ Muscle Aches/Pains
- ☐ Leg Cramps

HEMATOLOGY
- ☐ Easy Bruising
- ☐ Excessive Bleeding

NEUROLOGICAL
- ☐ Loss of Bowel Control
- ☐ Dizziness and/or Lightheaded
- ☐ Headaches
- ☐ Numbness/Tingling
- ☐ Passing Out

ENDOCRINE
- ☐ Appetite Changes
- ☐ Increased Thirst
- ☐ Drinking a Lot of Fluids
- ☐ Urinating a Lot

Has anyone in your FAMILY ever had? (IF YES CHECK THE BOX AND LIST RELATIONSHIP
- ☐ Dialysis _____
- ☐ Kidney Stones _____
- ☐ Kidney Disease _____
- ☐ Cancer & Type _____
- ☐ Diabetes _____
- ☐ Congestive Heart Failure _____
- ☐ Coronary Artery Disease _____
- ☐ High Blood Pressure _____
- ☐ High Cholesterol _____
- ☐ Stroke _____

Medication Allergies:

Medication:	Type of Reaction:

Medication List:

Medication	Dosage	Times a day

Recent Hospital Admissions:

Name of Hospital	Date of Admission	Date of Discharge	Reason