RENAL MEDICINE ASSOCIATES

# New Patient Medical History Form

Your answers on this form will help your provider get an accurate history of your medical conditions

Have you been Hospitalized, seen in the ER or Urgent Care recently ☐Yes ☐ No

If yes Where_____Date_____

Are you allergic to any drugs? (circle) No Yes if yes please list

_____ _____ _____

_____ _____ _____

**Immunizations** *(check if Yes and indicate year of last injection*

____Influenza _____ ____ Pneumonia _____ ____ Hepatitis B_____

Past Medical/Surgical Problems (please check yes or no)

| Yes | No | | Yes | No | | Yes | No | | Yes | No | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| ___ | ___ | stroke/TIA | ___ | ___ | seizures/epilepsy | ___ | ___ | diabetes mellitus | ___ | ___ | kidney disease |
| ___ | ___ | heart attack/angina | ___ | ___ | heart failure | ___ | ___ | enlarged prostate | ___ | ___ | kidney stones |
| ___ | ___ | heart arrhythmia | ___ | ___ | heart valve abnl | ___ | ___ | depression | ___ | ___ | HIV/AIDS |
| ___ | ___ | high blood pressure | ___ | ___ | high cholesterol | ___ | ___ | anxiety | ___ | ___ | hepatitis |
| ___ | ___ | asthma | ___ | ___ | COPD/emphys. | ___ | ___ | bleeding disorder | ___ | ___ | cirrhosis |
| ___ | ___ | stomach ulcer | ___ | ___ | thyroid disorder | ___ | ___ | pulmonary embolus/DVT | ___ | ___ | cancer |

Other , including operations _____

Systems Review ---are you currently ─ experiencing?

**Please check here if all are negative □**

**Constitutional**

__ Have fever or chills

__ Feel fatigued

__ Have a good appetite

__ Do you exercise

__ Any changes in weight since your last visit

**Psychological**

__ Anxious or depressed

**Pulmonary**

__ Shortness of breath

__ Coughing

__ Wheezing

**Heent**

__ Any eye problems or vision changes

__ Dry mouth

__ Any hearing changes

**Neurological**

__ Passed out since your last visit

__ Have pain in legs when walking

__ Have swelling in your legs

**Cardiovascular**

__ Have any chest pain or pressure

__Have irregular heartbeats/palpitations

__ Have any numbness in your feet or legs

__ Have any weakness

__ Have headaches

**Gastrointestinal**

__ Have abdominal pain

__ Have nausea or vomiting

__ Have diarrhea

__ Have constipation

__ Have any blood in your stool

__ Have heartburn or acid reflux

**Musculoskeletal**

__ Have back pain

__ Have joint pain or swelling

**Skin**

__Have a rash

__ Have itchy skin

__ Bruise easily

**Genitourinary**

__ Have burning when urinating

__ Have bloody or foamy urine

__ Have trouble holding your urine

__Thirsty all the time

__ Get up more than 3 times at night to urinate

__Feel that you do not empty your bladder after you urinate

**Endocrinology**

__ Have hot flashes

__ Is your Diabetes under control

**MEDICATION LIST**

[Please complete the following medication list before coming to your appointment]

**Patient Name: _____ Date of Birth: _____**

**Are you allergic to any medications? (Please list):**

_____

_____

**Please provide the names of ALL medications you are currently taking, this includes *any* OTC (over the counter) medications and supplements. Be sure to include: **Medication Name, Dosage/strength (e.g.; mg, mcg, mEq), and frequency of use (e.g., daily, 2 times a day).** *If you are unsure about any medication please bring all of your bottles in with you for your appointment.*

| | Medication: | Dose (mg): | How often do you take: |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |
| 5. | | | |
| 6. | | | |
| 7. | | | |
| 8. | | | |
| 9. | | | |
| 10. | | | |
| 11. | | | |
| 12. | | | |
| 13. | | | |
| 14. | | | |
| 15. | | | |
| 16. | | | |
| 17. | | | |

18. _____ _____ _____

19. _____ _____ _____

20. _____ _____ _____

21. _____ _____ _____

22. _____ _____ _____

23. _____ _____ _____

24. _____ _____ _____

25. _____ _____ _____

26. _____ _____ _____

27. _____ _____ _____

28. _____ _____ _____

29. _____ _____ _____

30. _____ _____ _____

Notes/Comments for Physician: _____

_____

_____

_____

_____

_____

**Please make sure all information is filled out before you come in for your appointment. This information is very important to give you the best care possible. As your partner in health, we thank you for taking the time to fill out all paperwork necessary.**

Thank you,

Your care team at Renal Medicine Associates.