Augusta Renal Physicians, P.C.

NAME _____ **AGE** ____ **DATE** _____

MARITAL STATUS: **MARRIED** **SINGLE**
DIVORCED **SEPARATED**
WIDOWED **OTHER**
(CIRCLE ONE)

ETHNICITY: WHAT IS YOUR ETHNIC BACKGROUND?

☐ AFRICAN AMERICAN ☐ ALASKAN NATIVE
☐ ASIAN ☐ LATINO ☐ NATIVE AMERICAN
☐ PACIFIC ISLANDER ☐ WHITE ☐ OTHER

OCCUPATION/PROFESSION _____

CURRENT EMPLOYER _____

PLACE OF BIRTH _____

BIRTHDATE _____

_____YEARS	_____YEARS	_____YEARS
HIGH SCHOOL	**COLLEGE**	**POST GRAD.**

DATE OF LAST PHYSICAL EXAM _____

WAS YOUR LAST EXAM A ROUTINE CHECK-UP? _____
PLEASE LIST ALL SYMPTOMS - (IF ANY)

PLEASE LIST THE NAMES AND ADDRESSES OF DOCTORS THAT YOU HAVE SEEN IN THE PAST --

	DOCTOR	**ADDRESS**
1- _____	_____	_____
2- _____	_____	_____
3- _____	_____	_____
4- _____	_____	_____
5- _____	_____	_____

	IF LIVING		IF DECEASED	
FAMILY HISTORY	**AGE**	**HEALTH**	**AGE AT DEATH**	**CAUSE**
FATHER				
MOTHER				
BROTHER OR SISTER				
HUSBAND OR WIFE				
SON OR DAUGHTER				

HAS ANY BLOOD RELATIVE EVER HAD:	PLEASE CIRCLE NO OR YES		RELATIONSHIP
CANCER	NO	YES	_____
TUBERCULOSIS (TB)	NO	YES	_____
DIABETES	NO	YES	_____
HEART TROUBLE	NO	YES	_____
HIGH BLOOD PRESSURE	NO	YES	_____
KIDNEY DISEASE	NO	YES	_____
STROKE	NO	YES	_____
EPILEPSY	NO	YES	_____
MENTAL ILLNESS	NO	YES	_____
SUICIDE	NO	YES	_____

NOTE THIS IS A CONFIDENTIAL RECORD OF YOUR MEDICAL HISTORY AND WILL BE KEPT IN THIS OFFICE. INFORMATION CONTAINED HERE WILL NOT BE RELEASED TO ANY PERSON EXCEPT WHEN YOU HAVE AUTHORIZED US TO DO SO —

PERSONAL HISTORY	PLEASE CIRCLE NO OR YES	
ILLNESSES: Have you ever had -		
MEASLES	NO	YES
GERMAN MEASLES	NO	YES
MUMPS	NO	YES
CHICKEN POX	NO	YES
WHOOPING COUGH	NO	YES
SCARLET FEVER OR	NO	YES
SCARLETINA	NO	YES
DIPTHERIA	NO	YES
SMALLPOX	NO	YES
PNEUMONIA	NO	YES
INFLUENZA	NO	YES
PLEURISY	NO	YES
RHEUMATIC FEVER OR	NO	YES
HEART DISEASE	NO	YES
ARTHRITIS	NO	YES
ANY BONE DISEASE OR	NO	YES
JOINT DISEASE	NO	YES
NEURITIS OR NEURALGI.	NO	YES
BURSITIS	NO	YES
BACK PAIN	NO	YES
POLIO OR MENINGITIS	NO	YES
NEPHRITIS	NO	YES
GONORRHEA OR	NO	YES
SYPHILIS	NO	YES
GALLBLADDER DISEASE	NO	YES
ANEMIA	NO	YES
JAUNDICE	NO	YES
BLADDER DISEASE	NO	YES
EPILEPSY	NO	YES
MIGRAINE HEADACHES	NO	YES
TUBERCULOSIS (TB)	NO	YES
DIABETES	NO	YES
LOW BLOOD SUGAR	NO	YES
HIGH BLOOD PRESSURE	NO	YES
LOW BLOOD PRESSURE	NO	YES
COLITIS	NO	YES
BOWEL DISEASE	NO	YES
HEMORRHOIDS	NO	YES
ANY RECTAL DISEASE	NO	YES
NERVOUS BREAKDOWN	NO	YES
FOOD, CHEMICAL OR	NO	YES
DRUG POISONING	NO	YES
HAY FEVER OR ASTHMA	NO	YES
SKIN PROBLEMS	NO	YES
FREQUENT INFECTIONS	NO	YES
CANCER	NO	YES
AIDS	NO	YES
ANY OTHER DISEASE	NO	YES
TRANSFUSIONS:		
Have you ever had Blood or Plasma Transfusion	NO	YES

	PLEASE CIRCLE NO OR YES	
ALLERGIES: Are you allergic to -		
PENICILLIN OR SULFA	NO	YES
ASPIRIN	NO	YES
CODEINE OR MORPHINE	NO	YES
ANY ANTIBIOTICS	NO	YES
IODINE	NO	YES
CONTRAST MATERIAL	NO	YES
ANY OTHER DRUG	NO	YES
ANY FOODS	NO	YES
ADHESIVE TAPE	NO	YES
TETANUS ANTITOXIN OR	NO	YES
SERUMS	NO	YES
ANYTHING NOT MENTIONED ABOVE	NO	YES
INJURIES: Have you had any -		
BROKEN BONES	NO	YES
CRACKED BONES	NO	YES
SPRAINS	NO	YES
LACERATIONS	NO	YES
DISLOCATIONS	NO	YES
CONCUSSION OR	NO	YES
HEAD INJURY	NO	YES
EVER BEEN KNOCKED UNCONSCIOUS	NO	YES
SURGERY: Have you had		
TONSILLECTOMY		
APPENDECTOMY		
ANY OTHER OPERATION		

LIST BELOW	YEAR
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Have you ever been advised to have any surgery that has not been done?	NO	YES
Have you ever been hospitalized?	NO	YES

If yes, please give details below -

_____

_____

_____

_____

_____

_____

SMOKING STATUS: ☐ NEVER SMOKER

☐ FORMER SMOKER

☐ CURRENT SMOKER

DO YOU NOW HAVE OR HAVE YOU HAD WITHIN THE PAST YEAR -

PLEASE CIRCLE NO OR YES

FREQUENT OR SEVERE HEADACHES	NO	YES
FAINTING SPELLS	NO	YES
DIZZINESS ON CHANGE OF POSITION	NO	YES
UNCONSCIOUS SPELLS	NO	YES
BLURRED VISION	NO	YES
DOUBLE VISION	NO	YES
SPOTS BEFORE EYES	NO	YES
INFECTED EYES	NO	YES
PAIN BEHIND EYES	NO	YES
ANY CHANGE IN VISION	NO	YES
DO YOU WEAR GLASSES?	NO	YES
IF YES, WHEN WERE THEY LAST CHECKED? _____		
EARACHES	NO	YES
DISCHARGE FROM EARS	NO	YES
RINGING IN EARS	NO	YES
DECREASE IN HEARING	NO	YES
RECURRENT NOSE BLEE	NO	YES
RECURRENT HEAD COLI	NO	YES
SINUS TROUBLE	NO	YES
HAY FEVER	NO	YES
STRANGE PERSISTENT ODORS	NO	YES
STRANGE TASTE OR	NO	YES
LOSS IN TASTE	NO	YES
PERSISTENT HOARSENESS	NO	YES
DIFFICULTY SWALLOWING	NO	YES
ENLARGED GLANDS	NO	YES
RECURRENT SORE THROA	NO	YES
RECURRENT MOUTH SORE	NO	YES
SORENESS OR BLEEDING OF GUMS ON BRUSHING	NO	YES
CHEST PAIN	NO	YES
ANGINA	NO	YES
COUGHED UP BLOOD	NO	YES
PAIN IN ARM(S)	NO	YES
NIGHT SWEATS	NO	YES
CHRONIC COUGH	NO	YES
SHORTNESS OF BREATH	NO	YES
PALPITATIONS OR FLUTTERING HEART	NO	YES
HIGH BLOOD PRESSURE	NO	YES
SWELLING OF HANDS, FEET OR ANKLES	NO	YES
LEG CRAMPS ON WALKING OR AT NIGHT	NO	YES
ENLARGED LEG VEINS	NO	YES
BELCHING OR HEARTBURN	NO	YES
IF YES, RELIEVED BY MEDICATION?	NO	YES
POOR APPETITE	NO	YES
NAUSEA OR VOMITING	NO	YES
VOMITED BLOOD	NO	YES
ABDOMINAL CRAMPING	NO	YES
ANY BLOOD IN STOOL	NO	YES
RECTAL PAIN WITH BM	NO	YES
PAIN ON URINATION	NO	YES
DIFFICULTY URINATING	NO	YES
DO YOU GET UP AT NIGHT TO URINATE	NO	YES
ANY BLOOD IN URINE	NO	YES
DISCHARGE FROM PENIS	NO	YES
LOSE URINE ON COUGHING OR SNEEZING	NO	YES
RECURRENT BACK PAIN	NO	YES
JOINT PAIN	NO	YES
SWELLING OF JOINTS	NO	YES
TINGLING OR WEAKNESS OF HANDS OR FEET	NO	YES
MUSCLE SPASMS	NO	YES
TREMBLING OF ANY EXTREMITY	NO	YES
LOSS OF FEELING IN HANDS OR FEET	NO	YES
GROWTH IN NECK OR THROAT	NO	YES
HOT FLASHES	NO	YES
LOSS OF ENERGY	NO	YES
DRY SKIN	NO	YES
BRITTLE NAILS	NO	YES
EASY BRUISING	NO	YES
INABILITY TO STAND HEAT	NO	YES
INABILITY TO STAND COLD	NO	YES
ANY SKIN RASH	NO	YES

EKG:

Have you ever had an electrocardiogram?	NO	YES

X-RAYS: Have you ever had x-rays of -	PLEASE CIRCLE NO OR YES	
CHEST	NO	YES
STOMACH OR COLON	NO	YES
GALL BLADDER	NO	YES
EXTREMITIES	NO	YES
BACK	NO	YES
KIDNEYS	NO	YES
OTHER	_____	
	_____	
	_____	

DRUGS:	PLEASE CIRCLE ONE			
LAXATIVES	NEVER	ON OCCASION	FREQUENTLY	DAILY
VITAMINS	NEVER	ON OCCASION	FREQUENTLY	DAILY
SEDATIVES	NEVER	ON OCCASION	FREQUENTLY	DAILY
ASPIRIN	NEVER	ON OCCASION	FREQUENTLY	DAILY
MOTRIN	NEVER	ON OCCASION	FREQUENTLY	DAILY
ADVIL	NEVER	ON OCCASION	FREQUENTLY	DAILY
PAIN MED.	NEVER	ON OCCASION	FREQUENTLY	DAILY
ALCOHOL	NEVER	ON OCCASION	FREQUENTLY	DAILY

LIST ANY MEDICATIONS THAT YOU TAKE ON A REGULAR BASIS --

_____
_____
_____
_____
_____
_____
_____

IMMUNIZATIONS: LIST ALL IMMUNIZATIONS IN LAST 10 YEARS --	YEAR
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Have you ever taken Insulin or pills for Diabetes?	NO	YES
Have you ever taken hormone tablets or injections?	NO	YES

WOMEN ONLY - MENSTRUAL HISTORY

AGE AT ONSET	_____	
REGULAR?	NO	YES
DATE OF LAST PELVIC EXAM -	_____	
DATE OF LAST PAP TEST	_____	
ANY VAGINAL DISCHARGE	NO	YES
DO YOU TAKE BIRTH CONTROL PILLS?	NO	YES
IF YES, HOW LONG HAVE YOU TAKEN THEM?	_____	

PREGNANCIES:

HOW MANY CHILDREN BORN ALIVE?	_____
HOW MANY CESAREAN SECTIONS?	_____
HOW MANY PREMATURE BIRTHS?	_____
HOW MANY MISCARRIAGES?	_____
HOW MANY STILL BIRTHS?	_____

DESCRIBE ANY COMPLICATIONS WITH PREGNANCY --

_____
_____
_____
_____