

SUFFOLK NEPHROLOGY CONSULTANTS, P.C.
PATIENT'S HEALTH HISTORY FORM

Dear Patient please fill in both page 1, and page 2 (please see over)

Page 1

Name: _____

Date : _____

Date of Birth: _____

Referring M.D.: _____

Reason for referral: _____

Other M.D.'s currently seeing: _____

PAST MEDICAL HISTORY (please check Yes or No)

**OTHER MEDICAL CONDITIONS
OR DETAILS OF EXISTING CONDITIONS**

(please describe in the space below)

Diabetes Yes No

High Blood Pressure

Heart disease

Heart Attack

High Cholesterol

Pacemaker / AICD

Kidney Disease
(chronic)

Kidney stones

Anemia

Stroke / CVA / TIA Yes No

Arthritis

Cancer

Asthma / COPD

Congestive heart failure

Peripheral vascular disease

Blood clots

Acute kidney failure

Liver Disease

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PAST SURGICAL HISTORY (please list below important surgeries you had in the past):

Page 2

Hospitalization (Past Year) Yes ___ No ___ If Yes, name of Hospital: _____

Reason for hospitalization: _____

REVIEW OF SYSTEMS (please mark YES – Y, NO -N if you have any of following symptoms)

Constitutional	Y	N	HEENT	Y	N	Respiratory	Y	N	Cardiovascular	Y	N
Weight Loss			Decreased vision			Shortness of breath			Chest Pain		
Weight Gain			Blurry vision			Cough			Palpitations		
Fever			Diabetic retina disease			Wheezing			Edema / leg swelling		
Chills			Bleeding behind the eye			Difficulty breathing			Fainting episodes		
Excessive tiredness			Other			Lung disease			Leaky heart valves		
Gastrointestinal	Y	N	Genitourinary	Y	N	Musculoskeletal	Y	N	Skin	Y	N
Nausea			Burning on urination			Joint aches			Itchy skin		
Vomiting			Blood in urine			Joint Swelling			Rashes on body		
Poor appetite			Frequent urination			Muscle aches			Dry skin		
Diarrhea			Urinary tract infections			Muscle swelling					
Blood in stool			Kidney stones in past			Pain killer use			Other symptoms (describe)		
Neurologic	Y	N	Endocrine	Y	N	Hematologic	Y	N			
Confusion			Excess thirst			Easy bruising					
Lightheadedness			Cold Intolerance			Blood clots					
Severe headaches			Heat Intolerance			Bleeding disorder					
Numbness in feet			Large amount urine								

SOCIAL HISTORY: Marital status _____ Occupation _____
 Non-smoker (never smoked) _____ Ex-smoker (year quit) _____ Current smoker _____ cigarettes / day _____
 Alcohol consumption, occasional _____, frequent _____, never _____

FAMILY HISTORY: (please list any known medical problems)
 Father: _____
 Mother: _____
 Siblings: _____
 Your Children: _____

ADDITIONAL INFORMATION: (Use this space to provide any additional information important to your health)

 Signature of Reviewing Physician Date

 Signature of Patient Date

 Signature of Nurse Practitioner Date