SUMMIT KIDNEY AND HYPERTENSION CARE

Health History

Last name: _____ **First name:** _____ **DOB:** _____

Reason for your visit today:

_____

_____

_____

Personal Medical History

Constitutional *e.g., fever, heat stroke, weight loss, weight gain, unusually tired, etc.*

☐ Yes ☐ No

Comments: _____

Ear/Nose/Throat *e.g., hard of hearing, stuffy nose, earache, cough, dry mouth, etc.*

☐ Yes ☐ No

Comments: _____

Heart (Cardiovascular) *e.g., high blood pressure, racing pulse, chest pain, unable to exercise, etc.*

☐ Yes ☐ No

Comments: _____

Lungs (Respiratory) *e.g., congestion, wheezing, shortness of breath, productive or bloody cough, asthma, etc.*

☐ Yes ☐ No

Comments: _____

Digestion (Gastrointestinal) *e.g., stomach upset, diarrhea, constipation, hernia, ulcers, pain/cramps, acid reflux, etc.*

☐ Yes ☐ No

Comments: _____

Muscles and bones (Musculoskeletal) *e.g., muscle pain/cramps, joint pain swelling, stiffness, etc.*

☐ Yes ☐ No

Comments: _____

Urological *e.g., painful or frequent urination, burning, impotence, incontinence, infections, etc.*

☐ Yes ☐ No

Comments: _____

Gynecological *e.g., pregnancies, menstrual problems, ovarian and uterine conditions, etc.*

☐ Yes ☐ No

Comments: _____

Breast *e.g., cysts, fibroids, pain, numbness, lumps, etc.*

☐ Yes ☐ No

Comments: _____

Neurological *e.g., numbness, weakness, headaches, paralysis, seizures, tremors, tingling, etc.*

☐ Yes ☐ No

Comments: _____

Psychiatric *e.g., depression, anxiety, mood swings, insomnia, hallucinations, disorientation, etc.*

☐ Yes ☐ No

Comments: _____

Blood/Lymphatic *e.g., high cholesterol, anemia, blood disorders, leukemia, prolonged bleeding, etc.*

☐ Yes ☐ No

Comments: _____

Skin *e.g., itching, rash, infection, ulcer, tumors or growths, warts, excessive dryness, etc.*

☐ Yes ☐ No

Comments: _____

Cancer

☐ Yes ☐ No

Comments: _____

Allergic/Immunologic *e.g., recurrent infections, hay fever, food allergy, drug sensitivity, hives, redness, itching, etc*

☐ Yes ☐ No

Comments: _____

Hormones (Endocrine) *e.g., diabetes, thyroid problems, fatigue, hair loss, hot/cold intolerance, etc.*

☐ Yes ☐ No

Comments: _____

IF DIABETIC:

Doctor and contact information: _____

Year of diagnosis: _____ **Result/Time of last blood sugar:** _____

Last hemoglobin A1C: _____ **Treatments:** _____

Major illnesses/Hospitalizations

☐ Yes ☐ No

Comments: _____

Surgeries

☐ Yes ☐ No

Comments: _____

Family History

(Parents, Siblings, or Grandparents only)

Autoimmune disease	
Kidney Stones	
Systemic Disease	
☐ Diabetes ☐ Cancer ☐ Heart disease	☐ Hypertension ☐ Arthritis ☐ Other:

PERSONAL SOCIAL HISTORY

Marital status: _____

Living arrangements: _____

Have you been exposed to venereal disease/sexually transmitted infection?

☐ Yes ☐ No

Are you pregnant?

☐ Yes ☐ No

Occupation(s): _____

Occupational exposure:

☐ Yes ☐ No

Recent travel:

☐ Yes ☐ No

Tobacco use

☐ Never ☐ Current everyday use ☐ Current intermittent use ☐ Former use ☐ Status unknown ☐ Other:_____

Alcohol use

☐ Never ☐ Current everyday use ☐ Current intermittent use ☐ Former use ☐ Status unknown ☐ Other:_____

Recreational drug use

☐ Never ☐ Current everyday use ☐ Current intermittent use ☐ Former use ☐ Status unknown ☐ Other:_____

Medications: *List ALL medications you are CURRENTLY taking. (Include all herbals, vitamins and supplements)*

Name	Dose	Frequency	Other information

IF MEDICATION LIST GOES BEYOND THE SPACE PROVIDED, THEN PLEASE ATTACH A SEPARATE SHEET

Allergies: *Please list ALL allergies*

Allergy	Severity	Reaction	Treatment Information

Preferred pharmacy:

Name	Pharmacy Location Number	Address	Phone Number	Fax Number

Signature _____ **Date** _____

Printed name _____