Kidney Specialists of Central Oklahoma, PC
Patient History

Name *(Last, First, M.I.)* :	□ M □ F	DOB:
Primary or referring doctor:		Today's date:
Emergency Contact:	Role:	Phone:

Please list other physicians you see and for what reason.

Name of Physician	Reason

Past Medical History (please circle Y/N)

Acute Kidney Injury	Y	N	Gastric reflux disease	Y	N	Lupus	Y	N
Anemia	Y	N	Gout	Y	N	Myocardia infarction	Y	N
Irregular heartbeat	Y	N	Hepatitis B	Y	N	Nephrotic syndrome	Y	N
Cancer	Y	N	Hepatitis C	Y	N	Osteoporosis	Y	N
Congestive Heart Failure	Y	N	HIV/AIDS	Y	N	Polycystic kidney	Y	N
Chronic kidney disease	Y	N	Hyperkalemia	Y	N	Pyelonephritis	Y	N
Clotting disorder	Y	N	Hyperparathyroidism	Y	N	Renal cyst	Y	N
Chronic obstructive pulmonary disease	Y	N	Hypertension	Y	N	Sleep apnea	Y	N
Coronary artery disease	Y	N	Hyponatremia	Y	N	Stroke	Y	N
Diabetes mellitus	Y	N	Hypothyroidism	Y	N	Mini-stroke	Y	N
Diabetes nephropathy	Y	N	Kidney Stones	Y	N	Urinary tract infection	Y	N
Enlarged prostrate	Y	N						
End stage renal disease	Y	N						

effective 10/1/2019

Kidney Specialists of Central Oklahoma, PC

Patient History

Name *(Last, First, M.I.)* :	◻ M ◻ F	DOB:

Past Surgical History (please circle Y/N; if not listed write in "Other" box)								
Abdomen surgery	Y	N	Kidney biopsy	Y	N	Kidney transplant recipient living related donor	Y	N
Bladder surgery	Y	N	Kidney removal	Y	N	Kidney transplant recipient living unrelated donor	Y	N
Cardiac bypass surgery	Y	N	Kidney stone surgery	Y	N	Lithotripsy	Y	N
Cardiac stent	Y	N	Kidney transplant	Y	N	Parathyroid surgery	Y	N
Dialysis access surgery	Y	N	Kidney transplant recipient deceased	Y	N	Thyroid Surgery	Y	N
Gallbladder surgery	Y	N	Other:			Other:		

Family History (please mark appropriate box with an "X"

Relative	No Known Problem	Anemia	Autimmune	Cancer	Diabetes	Hypertension	Kidney disease	Stroke	Heart disease	Demential	Gout	Arthritis	Asthma	Polycystic Kidney Disease
Mother														
Father														
Sister														
Brother														

☐ Adopted

☐ Family History Unkown

effective 10/1/2019

Kidney Specialists of Central Oklahoma, PC
Patient History

Name *(Last, First, M.I.)* :	□ M □ F	DOB:

Social History

Current Marital Status	□ Married	□ Single	□ Widowed
	□ Separated	□ Divorced	
Living Arrangement	□ Alone	□ Spouse	□ Significant other
	□ Family member	□ In home caregiver	□ Assisted living center
Occupation	□ Retired	□ Employed	
	□ Unemployed	□ Student	

If formerly or currently employed, please indicate occupation: ___________________________________

Do any of the following impact your daily living?	□ Hearing loss	□ Poor vision or blind	□ Memory loss
	□ Limited mobility	□ Transportation	□ No impairments

Habits

Tobacco Use	□ Current user	□ Former user		□ Never used
Type	□ Cigarettes	Packs/day:_________________	□ Pipe	□ Snuff
	□ Cigars	□ Chewing tobacco	□ E-cigarettes	□ Vaping

Date Started: __________________________ **Date Quit:** __________________________

Alcohol Use	□ Current user	□ Former user	□ Never used
Amount	□ Occasional	□ 1-2 drinks per day	□ 3 or more drinks per day
	Glasses of Wine/week: _______	Cans of Beer/week: _______	Shots of Liquor/week: _______

Date Quit:__________________________________

Recreational drug use	□ Current user	□ Former user	□ Never used
Type of drug used	□ Marijuana	□ Heroin	□ Cocaine
	□ Amphetamines	□ Ecstasy	□ Barbiturates
	□ LSD	□ Opium	□ Other:____________

Date Quit:__________________________________

Allergy List

Name of the Allergen	Reaction you had

Immunizations	□ Influenza (flu) _________________	□ Tetanus _________________
	□ Pneumovax _________________	□ Hepatitis B _________________
Include approximate dates	□ Other _________________	

Kidney Specialists of Central Oklahoma, PC
Patient History

Name *(Last, First, M.I.)* :	□ M □ F	DOB:

Have you recently experienced any of the following? (check all that apply)

CONSTITUTIONAL
- □ Fever
- □ Chills
- □ Weight loss
- □ Malaise / Fatique
- □ Excessive sweating
- □ Weakness

SKIN
- □ Rash
- □ Itching

HENT
- □ Hearing loss
- □ Ringing in ears
- □ Ear pain
- □ Ear discharge
- □ Nosebleeds
- □ Congestion
- □ Sore throat

EYES
- □ Blurred vision
- □ Double vision
- □ Difficulty with bright lights
- □ Eye pain
- □ Eye redness

CARDIOVASCULAR
- □ Chest pain
- □ Irregular heartbeat
- □ Shortness of breath
- □ Abnormal clotting
- □ Leg swelling
- □ Night coughing

RESPIRATORY
- □ Cough
- □ Coughing up blood
- □ Coughing up phlegm
- □ Shortness of breath
- □ Wheezing

GI
- □ Heartburn
- □ Nausea
- □ Vomiting
- □ Abdominal pain
- □ Diarrhea
- □ Bood in stool
- □ Dark sticky BM

URINARY SYSTEM
- □ Difficulty urinating
- □ Urgency when urination
- □ Frequent urinating
- □ Blood in urine
- □ Flank pain

MUSCULOSKELETAL
- □ Muscle soreness
- □ Neck pain
- □ Back pain
- □ Joint pain
- □ Falls

ENDO/HEME/ALERGY
- □ Easy bruise/bleed
- □ Environ. allergies
- □ Excessive thirst

ENDO/HEME/ALERGY
- □ Dizziness
- □ Headaches
- □ Tingling hands/feet

TREMOR
- □ Numbness
- □ Speech change
- □ Focal weakness
- □ Seizures
- □ Loss of consiousness

PSYCHIATRIC
- □ Depression
- □ Suicidal ideas
- □ Substance abuse
- □ Hallucinations
- □ Nervous / anxious
- □ Insomnia
- □ Memory loss

effective 10/1/2019

Kidney Specialists of Central Oklahoma, PC
Patient History

Name *(Last, First, M.I.)* :	◻ M ◻ F	DOB:

Current Medications List (including vitamins & over-the-counter medications)

Attach sheet if necessary

Name of drug	**Strength**	**Frequency taken**	**Doctor**