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**

Preferred Lab (please circle): **DLO** **Other:** ______________________________

Allergy List	**No known drug allergies? Yes / No**
Name of the Allergen	**Reaction you had**

Immunizations	☐ Influenza (flu) ___________________	☐ Tetanus ___________________
	☐ Pneumovax ___________________	☐ Hepatitis B ___________________
Include approximate dates	☐ Other ___________________	

Pharmacy Information	
Name:	Location:
Name:	Location:

effective 10/22/2020

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**	**Prescribing Doctor**

Past Medical History (please circle Y/N)					
Chronic Kidney Disease	Y	N	Diabetes	Y	N
Hypertension	Y	N	Cancer	Y	N
Blindness	Y	N	Failed Hearing Screening	Y	N
Cataracts	Y	N	Glaucoma	Y	N
Atrial Fibrillation	Y	N	Coronary Artery Disease	Y	N
Congestive Heart Failure	Y	N	Peripheral Vascular Disease	Y	N
Asthma	Y	N	Pneumonia	Y	N
Chronic Bronchitis	Y	N	Sleep Apnea	Y	N
COPD / Emphysema	Y	N	Tuberculosis	Y	N
GERD	Y	N	Inflammatory Bowel Disease	Y	N
Hepatitis	Y	N	Irritable Bowel Syndrome	Y	N
Kidney Stones	Y	N	Urinary Tract Infection (UTI)	Y	N
Gout	Y	N	Osteoporosis	Y	N
Osteoarthritis	Y	N			
Dementia	Y	N	Stroke	Y	N
Parkinson’s	Y	N	TIA	Y	N
Seizures	Y	N			
Anxiety	Y	N	Depression	Y	N
Bipolar	Y	N			
Hyperparathyroidism	Y	N	Hypothyroidism	Y	N
Hyperthyroidism	Y	N			
Anemia	Y	N	Leukemia	Y	N
HIV / AIDS	Y	N	Rheumatoid Arthritis	Y	N
Lupus	Y	N			
Other (please explain):					

Past Surgical History (please circle Y/N; if not listed write in "Other" box)								
Abdomen surgery	Y	N	Gallbladder Surgery	Y	N	Kidney transplant recipient living related donor	Y	N
Bladder surgery	Y	N	Kidney Biopsy	Y	N	Kidney transplant recipient living unrelated donor	Y	N
Cardiac bypass surgery	Y	N	Kidney Removal	Y	N	Lithotripsy	Y	N
Cardiac stent	Y	N	Kidney Stone Surgery	Y	N	Parathyroid surgery	Y	N
Cystectomy / Bladder Removal	Y	N	Kidney transplant recipient deceased	Y	N	Thyroid Surgery	Y	N
Dialysis Access Surgery	Y	N	Other:			Other:		
If you have had any of these surgeries, please provide the approximate date next to the procedure.								

Family History (please mark appropriate box with an "X"														
Relative	Anemia	Autoimmune	Cancer	Diabetes	Hypertension	Kidney disease	Stroke	Heart disease	Dementia	Gout	Arthritis	Asthma	Polycystic Kidney Disease	
Mother														
Father														
Sister														
Brother														

Adopted

Family History Unknown

Social History

Tobacco Use	☐ Current user		☐ Former user		☐ Never used
	☐ Cigarettes Packs/day:________________			☐ Pipe	☐ Snuff
Type	☐ Cigars	☐ Chewing tobacco		☐ E-cigarettes	☐ Vaping
Date Started: ____________________________			Date Quit: ____________________________		
Total Years of Tobacco Use: ___________________					

Alcohol Use	☐ Current user	☐ Former user		☐ Never used
How often do you have a drink containing alcohol?	☐ Never	☐ Monthly or less		☐ 2-4 times per month
	☐ 2-3 times per week	☐ 4 + times per week		☐ Refuse to answer
If you do drink, what is the amount per day?	☐ 1-2 Drinks per day	☐ 3-4 Drinks per day	☐ 5-6 Drinks per day	☐ 7 + Drinks per day
Type of Alcohol	☐ Beer	☐ Wine		☐ Liquor
Date Quit:____________________________________				

Recreational Drug Use	☐ Current user	☐ Former user	☐ Never used
Type of drug used	☐ Crack Cocaine	☐ Amphetamines	☐ Anabolic Steroids
	☐ Barbiturates	☐ Cocaine	☐ Fentanyl
	☐ Heroin	☐ IV	☐ LSD
	☐ Marijuana	☐ Ecstasy	☐ PCP
	☐ Methamphetamines	Other: _______________	
Date Quit:____________________________________			

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?	☐ Impairment	☐ Memory Deficit	☐ Hearing Loss
	☐ Poor Vision or Blindness	☐ Limited Mobility	☐ Transportation Challenges

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

CONSTITUTIONAL	EYES	GI	ENDO / HEME / ALLERGY
□ Fever □ Chills □ Weight loss □ Weight gain □ Malaise / Fatigue □ Excessive sweating □ Weakness	□ Blurred vision □ Vision Impaired □ Double vision □ Difficulty with bright lights □ Eye pain □ Eye redness	□ Heartburn □ Loss of Appetite □ Difficulty Swallowing □ Nausea □ Vomiting □ Abdominal pain □ Diarrhea □ Blood in stool □ Dark sticky BM	□ Easy bruise/bleed □ Environ. Allergies □ Excessive thirst □ Dizziness □ Heat/Cold Intolerance □ Headaches □ Numbness □ Tingling hands/feet
SKIN	**CARDIOVASCULAR**	**URINARY**	**TREMOR**
□ Rash □ Wound □ Itching	□ Chest pain □ Irregular heartbeat □ Shortness of breath □ Abnormal clotting □ Leg swelling □ Night coughing	□ Difficulty urinating □ Urgency when urination □ Frequent urinating □ Urinary Hesitancy □ Urinary Incontinence □ Urination at nighttime □ Blood in urine □ Flank pain	□ Numbness □ Speech change □ Focal weakness □ Seizures □ Loss of consciousness
HENT	**RESPIRATORY**	**MUSCULOSKELETAL**	**PSYCHIATRIC**

□ Hearing loss
□ Ringing in ears
□ Ear pain
□ Ear discharge
□ Nosebleeds
□ Congestion
□ Sore throat
□ Hoarseness
	□ Cough
	□ Coughing up blood
	□ Coughing up phlegm
	□ Shortness of breath
	    □ At Rest
	    □ With Activity
	□ Wheezing
		□ Muscle soreness
		□ Muscle cramps
		□ Neck pain
		□ Back pain
		□ Joint pain
		□ Falls
			□ Depression
			□ Suicidal ideas
			□ Substance abuse
			□ Hallucinations
			□ Nervous / anxious
			□ Insomnia
			□ Memory loss