Patient Name _____ DOB _____

ADVANCED KIDNEY CARE OF CENTRAL FLORIDA

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131 Webb Dr, Suite C Davenport, FL 33837 PH: (863) 226-4676 | FAX: (888) 716-2003

NEW PATIENT HEALTH HISTORY

DEMOGRAPHICS				
Last Name	**First Name**		**DOB**	**Sex M F**
Address	**City**	**State**	**Zip**	
Phone (H)	**(W)**	**(C)**		
Referred By		**Primary Care Physician**		
Emergency Contact Name		**Phone**	**Relationship**	
Date of Last Physical Exam	**Doctor**			

CURRENT MEDICATIONS (List Strength, Frequency)	

ALLERGIES
Medication Allergies
Other Allergies (Food, Environmental)

PAST MEDICAL HISTORY - Do you have or have you ever had?				
[ ] High Blood Pressure	[ ] Rheumatic fever	[ ] Cancer (type)	[ ] Headaches	[ ] Gallstones
[ ] Heart Disease	[ ] Anemia (low blood)		[ ] Seizures	[ ] Gallstones
[ ] Heart Attack	[ ] Blood transfusions	[ ] Breast masses	[ ] Glaucoma	
[ ] Heart Failure	[ ] Excessive bleeding	[ ] Sexually transmitted disease	[ ] Osteoporosis	[ ] Liver Disease/Hepatitis
[ ] Stroke	[ ] Blood clots	[ ] HIV testing	[ ] Kidney stones	[ ] Stomach ulcers
[ ] Blocked arteries	[ ] Splenectomy	[ ] HIV/AIDS	[ ] Urinary infections	[ ] Colon Disease
[ ] Diabetes	[ ] Asthma/Allergy	[ ] Arthritis	[ ] Kidney disease	[ ] Anxiety
[ ] High cholesterol	[ ] Emphysema/COPD	[ ] Lupus	[ ] Prostate disease	[ ] Depression
[ ] Thyroid Disease	[ ] Pneumonia or TB	[ ] Gout	[ ] Esophageal reflux	[ ] Other

PREVIOUS HOSPITALIZATIONS (Date, Reason, Hospital)

SURGERIES/OPERATIONS (Date, Type, Reason, Hospital)

Patient Name _____ DOB _____

IMMUNIZATIONS/VACCINES (Include Dates)				
[ ] Pneumonia	[ ] Tetanus	[ ] Influenza	[ ] Zostavax (Shingles)	[ ] HPV (Gardisil)
[ ] Hepatitis B	[ ] 2nd MMR Vaccine (If born after 1956)	[ ] TB Skin Test		

HEALTH SCREENING (Include Dates)			
[ ] Mammogram	[ ] PAP Smear	[ ] Colonoscopy	[ ] Prostate Exam

FAMILY HISTORY	Sex	Living	Deceased	Age	Diseases (Include Diabetes, Stroke, Cancer, Blood disease, Heart Disease/Heart Attack, Thyroid disorders, Seizures, Bleeding disorders, Kidney disease, Kidney stones, High blood pressure, Cancers, Psychiatric disorders)
Father	M				
Mother	F				
Brothers/Sisters (circle sex)	M F				
	M F				
	M F				
	M F				
	M F				
Sons/Daughters (circle sex)	M F				
	M F				
	M F				
	M F				
	M F				
Aunts/Uncles (circle sex)	M F				
	M F				
	M F				
Grandmother/Grandfather	M F				
	M F				

LIFESTYLE/SOCIAL HISTORY		
Occupation	**Highest Education Level:** [ ] Middle school [ ] High school [ ] College [ ] Post Graduate [ ] Other	**Marital Status** S M D W
Exercise (Type & Frequency per week)		
Caffeine on a regular basis? [ ] Yes [ ] No How many cups/cans per day?		
Smoking History [ ] Never [ ] Age started [ ] Age stopped	Packs per day: Currently	In the past
Alcohol Use [ ] Daily [ ] Occasional [ ] Rare [ ] None		
Recreational Drug (Now or In the Past) [ ] Marijuana [ ] Cocaine [ ] IV drugs [ ] Other		
Who lives with you at home? [ ] Alone [ ]Spouse/Partner [ ]Children [ ]Boyfriend/Girlfriend [ ]Nephews/Nieces [ ]Grandchildren		
Religious preference if any		
Sexual preference: [ ] Heterosexual [ ] Homosexual [ ] Bisexual	**Hobbies/Interests**	

REVIEW OF SYSTEMS (Circle any symptoms you experienced recently)				
General	**Ears**	**Eyes**	**Nose**	**Throat**
Weight gain	Hearing loss	Vision loss	Nosebleeds	Hoarseness
Weight loss	Ringing in ears	Blurry vision	Nasal congestion	Sore throat
Loss of appetite	Wax problems	Double vision	Snoring	Itchy throat
Night sweats	Ear pain	Painful eyes	Post nasal drip	Difficulty swallowing
Weakness		Redness	Decreased smell	Painful swallowing
Fatigue		Drainage		
Swollen glands				
Cardiovascular	**Respiratory**	**Gastrointestinal**	**Urinary**	**Allergy**
Chest pain/tightness	Persistent cough	Nausea/Vomiting	Painful urination	Sinus congestion
Irregular heartbeat	Bloody sputum	Abdominal pain	Flank pain	Hives
Palpitations	Difficulty breathing	Heartburn	Frequent Nighttime urination	Itchy eyes
Swollen legs	Wheezing	Diarrhea	Urine leakage	Runny nose
Leg pain/cramps	Painful breathing	Constipation	Difficulty urinating	
		Bloody stools	Frequent urination	
		Black tarry stools	Blood in urine	
		Mucous in stool	Foamy urine	
		Rectal pain	Recurrent UTI's	
			Penile/Vaginal discharge	

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Neuro	Skin	Musculoskeletal	Hematologic	Psychiatric
Headache	Rash	Joint pain	Easy bruising	Difficulties with sleep
Numbness/tingling	Itchy skin	Joint swelling	Varicose veins	Stress
Memory difficulties	Dry skin	Joint redness	Excessive bleeding	Feeling depressed
Speech problems	Change in moles	Joint stiffness		Feeling anxious
Tremors	New mole	Muscle pain		Changes in mood
Difficulty walking	Hair loss	Back pain		Changes in behavior
Lightheaded	Heat intolerance			Suicidal thoughts
Dizzy/Vertigo	Cold intolerance			Eating disorder
Fainting				Domestic abuse

_____ _____ _____

Patient/Guardian Signature Relationship Date

_____ _____

Review by Date