Patient Focused • Quality Oriented • Physician Driven

Muncie	2525 University Ave., Suite 300	Muncie, IN 47303	ph 765•281•2000	fx 765•281•2040
Muncie	800 S. Tillotson Ave.	Muncie, IN 47304	ph 765•281•2000	fx 765•281•2044
Cancer Center	2401 University Ave.	Muncie, IN 47303	ph 765•281•2000	fx 765•281•2114
Marion	1399 N. Baldwin	Marion, IN 46952	ph 765•651•2620	fx 765•651•2630
New Castle	2200 Forest Ridge, Suite 120	New Castle, IN 47362	ph 765•593•2960	fx 765•593•2965
New Castle	1000 North 16th, Suite 240A	New Castle, IN 47362	ph 765•521•1461	

Nephrology History Form

Name: ______________________________ Date: ______________

Referring Physician: ______________________________ Date of birth: ______________

Medical History: ***Please check any of the conditions that represents a SIGNIFICANT problem for you***

General	**YES**	**Cardiovascular**	**YES**	**Genitourinary**	**YES**
Fever or chills		Chest pain w/activity		Burning or painful urination	
Night sweats		Heart skips beats		Frequent urination	
Recent weight change		Heart beats too fast		Blood in urine	
Fatigue		Passing out spells		Bladder infection	
Heat or cold intolerance		Heart murmur		Incontinence, dribbling	
Loss of appetite		Feet or ankle swelling		Change in stream	
Head and Neck	**YES**	**Musculoskeletal**	**YES**	Prostate problems	
Recent trauma		Swollen/red joints		Problems with erection	
Swelling in neck		Arm/leg weakness		**FEMALE;** Irregular menses	
Pain or stiffness in neck		Difficulty in walking		Painful intercourse	
Eyes, Ears, Nose, Throat	**YES**	Back pain		Discharge from nipples	
Prolonged hoarseness		Bone pain		Breast lumps	
Sore throat		**Gastrointestinal**	**YES**	Pelvic pain	
Dry eyes		Rectal bleeding		Groin swelling	
Pain or light sensitivity		Heartburn/Indigestion		**Neurologic**	**YES**
Earache or drainage		Abdominal pain		Light headed or dizziness	
Nose bleeds		Black tarry or stools		Speech disturbances	
Ringing in ears		Change in bowel habits		Convulsions or seizures	
Sores in mouth		Constipation or diarrhea		Numbness or tingling	
Endocrine	**YES**	Bloated or distended abdomen		Frequent headaches	
Swollen or tender glands		Difficulty swallowing		Memory loss	
Excessive thirst		Nausea or vomiting		Paralysis or weakness	
Lungs	**YES**	Vomiting blood		**Psychiatric**	**YES**
Wheezing or Coughing		**Skin**	**YES**	Depression	
Cough with sputum or blood		Rash, dryness, itching		Anxiety	
Chest pain with breathing		Change in skin or moles		Physical, verbal or sexual abuse	
Shortness of breath		Skin cancer		Drug problems	
Daytime Sleepiness		Bleeding or bruising tendencies		Nervous breakdown	
Snoring				Suicidal thoughts	

Past and Family Medical History: ***Please check if you or your family have ever had any of the following***

	You	**Family**		**You**	**Family**		**You**	**Family**
Hypertension			Irritable Bowel			Rheumatoid Arthritis		
Heart Disease			Jaundice			Thyroid Disease		
Stomach Ulcers			Blood Clots			Rheumatic Fever		
Seizure/Epilepsy			Depression			Liver Disease/Hepatitis		
Diabetes			Tuberculosis			Breathing Problems		
Cancer			Blood Disorders			Vision Problems		
Renal Disease			Lupus			Hearing Problems		
Ulcerative Colitis			Stroke			Glaucoma		
Other			Other			Other		

Please list all of your medications, including over the counter medications (If you need additional space please bring a list, including dosages, to your appointment.)

Name of Medication	Dosage	Number of Times Per Day	Reason for Medication

Please list all allergies including medications, food, and environmental

Medication, Food, Other	Reaction

Please list any RECENT hospitalization and an approximate date

Date	Reason for hospitalization

Please list any surgeries or operations you have had and an approximate date

Date	Reason for surgery or operation

Social History:

Marital Status: Single ❑ Divorced ❑ Married ❑ Widow/Widower ❑ Other ❑

Who lives at home with you? ____________________________ What are your hobbies?______________________________

Who to contact in case of an emergency and phone number:____

Current Occupation/Employer:____ Type of work: ________________________

Do you smoke? Yes ❑ No ❑ If yes, how many packs per day?__________________________________

Did you smoke? Yes ❑ No ❑ If yes, when did you quit? _______________________________________

Do you drink alcohol? Yes ❑ No ❑ If yes, indicate on average how much and check day, week, or month

_______Beer per: Day ❑ Week ❑ Month ❑

_______Glasses of wine per: Day ❑ Week ❑ Month ❑

_______Mixed drinks per: Day ❑ Week ❑ Month ❑

Do you have an advanced directive or a living will? Yes ❑ No ❑

Patient Signature ____ Date:________________________

Physician Initials ____ Date:________________________