

Midwest Nephrology Consultants, P.A. - Review of Health History -- Page One

Circle Y = YES, N = NO, or / Fill in blank if appropriate

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Reviewed by Dr. _____

Date: ____/____/____

Over

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Y / N MUSCULOSKELETAL:	Y / N NEUROLOGICAL:
Joint Pain? <i>If Yes, Where?:</i>	Headaches, <i>If Yes: How often:</i> <i>Daily [] Weekly [] Monthly or Less []</i>
Joint Swelling? <i>If Yes, Where?:</i>	Dizziness
Muscle Weakness	Passing Out
Difficulty Walking	Numbness: <i>If yes: Where? ()</i>
	Tingling
	Memory Loss: <i>If yes: For How Long? ()</i>
	Transient Ischemic Attack (TIA)
	Stroke
	<i>If Yes: How affected: _____</i>
Y / N MALES ONLY:	Y / N PSYCHIATRIC:
Have you had a prostate Exam? <i>If Yes: When? ()</i>	Anxiety
Have you had a PSA Test <i>If Yes: When? ()</i>	Depression
Testicle pain/lumps	Suicidal
	Insomnia
Y / N FEMALES ONLY:	Y / N HEMATOLOGICAL:
Do you have breast lump(s)? <i>If yes: Was Biopsy done? When? ()</i>	Anemic
Have you had a Mammogram? <i>If yes: When? ()</i>	Blood Transfusion: <i>If Yes: When? ()</i>
Nipple Discharge	Erythropoietin (Anemia) Shots
Vaginal Discharge	Easy Bruising
Last Menstrual Period: ()	Easy Bleeding
On Current Hormonal Rx	Y / N SURGERY SINCE LAST VISIT:
On Past Hormonal Rx <i>If yes: What? ()</i> <i>If yes: Date Stopped ()</i>	What and When?
Y / N SKIN:	Other Comments:
Do You/Have You, had a Rash? <i>If yes: Where? ()</i>	
Itching	
Nail Changes	
Thinning Hair	
Increased Hair Growth	
Varicose Veins	

Reviewed by Dr. _____

Date: _____

Patient Name: _____ D/O/B: ____/____/____