PENINSULA KIDNEY ASSOCIATES
HEALTH HISTORY
(CONFIDENTIAL)

Name:_____ Date:_____

Date of Birth:_____ Age:_____ Date of Last Physical:_____

Conditions: Check (X) conditions you currently have or have had in the past.

- ☐ Aids
- ☐ Alcoholism
- ☐ Anemia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cardiovascular Disease
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Dementia
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problems
- ☐ Psychiatric Area
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Urinary Tract Infection
- ☐ Vaginal Infections
- ☐ Venereal Disease

Past Surgical History/ Hospitalizations Please include Procedure and Date.

- ☐ Abdominal_____
- ☐ Bladder_____
- ☐ Cardiac_____
- ☐ Cardiovascular_____
- ☐ Colon_____
- ☐ ENT_____
- ☐ Gastrointestinal_____
- ☐ GYN_____
- ☐ Neurosurgery_____
- ☐ Orthopedic_____
- ☐ Prostate_____
- ☐ Renal_____
- ☐ Thyroid_____
- ☐ Vascular_____

Medications Please List Dosage

_____
_____
_____
_____
_____
_____
_____
_____
_____

Allergies:

_____
_____
_____
_____
_____
_____
_____
_____
_____

Family Medical History: fill in health information about your family.

	Mother	Father	Sibling	Grandmother	Grandfather
☐ Arthritis	_____	_____	_____	_____	_____
☐ Asthma	_____	_____	_____	_____	_____
☐ Cancer	_____	_____	_____	_____	_____
☐ Diabetes	_____	_____	_____	_____	_____
☐ Heart Disease	_____	_____	_____	_____	_____
☐ High Blood Pressure	_____	_____	_____	_____	_____
☐ Stroke	_____	_____	_____	_____	_____
☐ Kidney Disease	_____	_____	_____	_____	_____
☐ Tuberculosis	_____	_____	_____	_____	_____
☐ Other	_____	_____	_____	_____	_____

Social History: Please check (X) all that apply

☐ Alcohol	☐ Depressants	☐ Narcotics
☐ Amphetamines	☐ Ecstasy	☐ Stimulants
☐ Barbiturates	☐ Hallucinogens	☐ Tobacco
☐ Cocaine	☐ Marijuana	☐ Other_____

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

_____

Signature: Date: