

PAST MEDICAL, FAMILY AND SOCIAL HISTORY FORM

Name: ~~XX~~ M · F DOB: _____
 (Last, First, M.I.)

PAST MEDICAL HISTORY – COMMON DISEASES

Do you have a personal history of any of the following?

Kidney Disease	<input type="checkbox"/> CKD F XXXXXX MM Stage: A	<input type="checkbox"/> Dialysis A XXXX PD
	<input type="checkbox"/> Transplant XXXX MM	<input type="checkbox"/> Polycystic Kidney Disease MM
	<input type="checkbox"/> Cadaveric A MM MM	<input type="checkbox"/> Acute Kidney Injury
	<input type="checkbox"/> Living - Related MM MM MM	<input type="checkbox"/> Glomerulonephritis
Diabetes	MM Type 1 A	MM Type Unknown
	MM Type 2	
High Blood Pressure	<input type="checkbox"/> Essential	<input type="checkbox"/> White Coat Hypertension
	<input type="checkbox"/> Renovascular	<input type="checkbox"/> Conn's Syndrome
Ischemic Heart Disease	<input type="checkbox"/> Heart attack	<input type="checkbox"/> Coronary Stent
	<input type="checkbox"/> Angina	<input type="checkbox"/> CABG (Coronary Artery Bypass Graft)
	<input type="checkbox"/> Angioplasty	
Cancer	<input type="checkbox"/> Lung	<input type="checkbox"/> Lymphoma
	<input type="checkbox"/> Breast	<input type="checkbox"/> Kidney
	<input type="checkbox"/> Prostate	<input type="checkbox"/> Thyroid
	<input type="checkbox"/> Colon	<input type="checkbox"/> Leukemia
	<input type="checkbox"/> Melanoma	<input type="checkbox"/> Endometrial
	<input type="checkbox"/> Bladder	<input type="checkbox"/> Pancreatic
Stroke	<input type="checkbox"/> Stroke	
Gout	<input type="checkbox"/> Gout	

PAST MEDICAL HISTORY – ADDITIONAL CONDITIONS

Do you have a personal history of any of the following?

EENT	<input type="checkbox"/> Blindness	<input type="checkbox"/> Hearing Problems
	<input type="checkbox"/> Cataracts	<input type="checkbox"/> Glaucoma
Cardiovascular	<input type="checkbox"/> Atrial Fibrillation	<input type="checkbox"/> Valvular Heart Disease
	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Congestive Heart Failure
	<input type="checkbox"/> AICD (Cardiac Defibrillator)	<input type="checkbox"/> Mitral Valve Prolapse
Respiratory	<input type="checkbox"/> COPD	<input type="checkbox"/> Pneumonia
	<input type="checkbox"/> Chronic Bronchitis	<input type="checkbox"/> Tuberculosis
	<input type="checkbox"/> Asthma	<input type="checkbox"/> Sleep Apnea
	<input type="checkbox"/> Emphysema	

Gastrointestinal	<input type="checkbox"/> GERD (Gastric Reflux) <input type="checkbox"/> Stomach/Bowel Ulcers <input type="checkbox"/> Gall Bladder Disease <input type="checkbox"/> Hepatitis	<input type="checkbox"/> Inflammatory Bowel Disease <input type="checkbox"/> Irritable Bowel Syndrome <input type="checkbox"/> Gluten Intolerance <input type="checkbox"/> Lactose Intolerance
Genitourinary	<input type="checkbox"/> Enlarged Prostate <input type="checkbox"/> Kidney Stones	<input type="checkbox"/> Frequent UTIs (Urinary Tract Infections)
OB History	<input type="checkbox"/> Preeclampsia <input type="checkbox"/> Pregnancy Induced Hypertension	<input type="checkbox"/> Gestational Diabetes <input type="checkbox"/> History of Complicated Pregnancy
Musculoskeletal	<input type="checkbox"/> Osteoarthritis	<input type="checkbox"/> Osteoporosis
Neurological	<input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Seizures	<input type="checkbox"/> Parkinson's <input type="checkbox"/> Dementia
Psychiatric	<input type="checkbox"/> Depression	<input type="checkbox"/> Anxiety Disorder
Endocrine	<input type="checkbox"/> Hypothyroidism <input type="checkbox"/> Hyperthyroidism	<input type="checkbox"/> Adrenal Insufficiency
Hematology	<input type="checkbox"/> Anemia <input type="checkbox"/> Sickle Cell Disease <input type="checkbox"/> Sickle Cell Trait	<input type="checkbox"/> Blood Transfusion <input type="checkbox"/> Thalassemia
Immuno/Allergy	<input type="checkbox"/> HIV <input type="checkbox"/> AIDS	<input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Lupus

PAST MEDICAL HISTORY – SURGERY HISTORY

Have any of the following surgeries been performed on you?

- | | | |
|---|--|--|
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Hip Replacement | <input type="checkbox"/> Renal Transplant |
| <input type="checkbox"/> CABG | <input type="checkbox"/> Left <input type="checkbox"/> Bilateral | <input type="checkbox"/> Thyroidectomy |
| <input type="checkbox"/> Carotid Endarterectomy | <input type="checkbox"/> Right | <input type="checkbox"/> Tonsillectomy |
| <input type="checkbox"/> Cataract Surgery | <input type="checkbox"/> Knee Replacement | <input type="checkbox"/> Valve Replacement |
| <input type="checkbox"/> D & C | <input type="checkbox"/> Left <input type="checkbox"/> Bilateral | <input type="checkbox"/> AV Fistula |
| <input type="checkbox"/> Gall Bladder Removal | <input type="checkbox"/> Right | <input type="checkbox"/> AV Graft |
| <input type="checkbox"/> Gastric Bypass | <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> PD Catheter |
| <input type="checkbox"/> Hemorrhoidectomy | <input type="checkbox"/> Prostatectomy | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Hernia Repair | <input type="checkbox"/> Nephrectomy | |

Other Health Problems Not Listed Above:

FAMILY HISTORY – ILLNESSES

Do the following family members have any of the following medical conditions?

Kidney Disease	<input type="checkbox"/> Father	<input type="checkbox"/> Sibling
	<input type="checkbox"/> Mother	<input type="checkbox"/> Child
Diabetes	<input type="checkbox"/> Father	<input type="checkbox"/> Sibling
	<input type="checkbox"/> Mother	<input type="checkbox"/> Child
High Blood Pressure	<input type="checkbox"/> Father	<input type="checkbox"/> Sibling
	<input type="checkbox"/> Mother	<input type="checkbox"/> Child
Ischemic Heart Disease	<input type="checkbox"/> Father	<input type="checkbox"/> Sibling
	<input type="checkbox"/> Mother	<input type="checkbox"/> Child
Cancer	<input type="checkbox"/> Father	<input type="checkbox"/> Sibling
	<input type="checkbox"/> Mother	<input type="checkbox"/> Child
Stroke	<input type="checkbox"/> Father	<input type="checkbox"/> Sibling
	<input type="checkbox"/> Mother	<input type="checkbox"/> Child
Gout	<input type="checkbox"/> Father	<input type="checkbox"/> Sibling
	<input type="checkbox"/> Mother	<input type="checkbox"/> Child
ADPKD	<input type="checkbox"/> Father	<input type="checkbox"/> Sibling
	<input type="checkbox"/> Mother	<input type="checkbox"/> Child
Dementia	<input type="checkbox"/> Father	<input type="checkbox"/> Sibling
	<input type="checkbox"/> Mother	<input type="checkbox"/> Child

FAMILY HISTORY – STATUS

Father	<input type="checkbox"/> Living <input type="checkbox"/> Unknown	<input type="checkbox"/> Deceased <input type="checkbox"/> Age at Death: _____ <input type="checkbox"/> Cause of Death: _____
Mother	<input type="checkbox"/> Living <input type="checkbox"/> Unknown	<input type="checkbox"/> Deceased <input type="checkbox"/> Age at Death: _____ <input type="checkbox"/> Cause of Death: _____

Other Family History Not Listed Above:

SOCIAL HISTORY – GENERAL

Current Marital Status	<input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Single	<input type="checkbox"/> Widowed <input type="checkbox"/> Divorced
Living Arrangement	<input type="checkbox"/> Alone <input type="checkbox"/> Family Member <input type="checkbox"/> Spouse	<input type="checkbox"/> In Home Caregiver <input type="checkbox"/> Significant Other <input type="checkbox"/> Assisted Living Facility
Occupation	<input type="checkbox"/> Retired <input type="checkbox"/> Unemployed <input type="checkbox"/> Employed <ul style="list-style-type: none"> <input type="checkbox"/> Full - time <input type="checkbox"/> Part - time <input type="checkbox"/> Student List your Current or Former Occupation: _____	
Deficits	<input type="checkbox"/> Hearing Loss <input type="checkbox"/> Limited Mobility	<input type="checkbox"/> Poor Vision or Blindness <input type="checkbox"/> Transportation Challenges

SOCIAL HISTORY – HABITS

Tobacco Use	<input type="checkbox"/> Current or Former User <ul style="list-style-type: none"> <input type="checkbox"/> Cigarettes <input type="checkbox"/> Chewing Tobacco <input type="checkbox"/> Pipes <input type="checkbox"/> Snuff <input type="checkbox"/> Cigars 	<input type="checkbox"/> Never Used <input type="checkbox"/> Unknown
	If a current or former user, what year did you start? _____	
	If a former user, what year did you quit? _____	

	<p>Complete the following section if you are a current or former cigarette user:</p> <p>How often do you currently smoke or how often did you smoke before you quit?</p> <p><input type="checkbox"/> Every Day <input type="checkbox"/> Some Days <input type="checkbox"/> Unknown</p> <p>How many packs per day do you currently smoke or how many packs per day did you smoke before you quit?</p> <p>_____</p> <p>How many total years have you used cigarettes?</p> <p>_____</p>
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<p>Alcohol Use</p>	<p><input type="checkbox"/> Current or Former User <input type="checkbox"/> Never Used</p> <p><input type="checkbox"/> Occasional</p> <p><input type="checkbox"/> 1-2 per Day</p> <p><input type="checkbox"/> 3 or more per Day</p> <p>If a former user, what year did you quit?</p> <p>_____</p>
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<p>Recreational Drug Use</p>	<p><input type="checkbox"/> Current or Former User</p> <p><input type="checkbox"/> Marijuana <input type="checkbox"/> Opium</p> <p><input type="checkbox"/> Amphetamines <input type="checkbox"/> Cocaine</p> <p><input type="checkbox"/> LSD <input type="checkbox"/> Barbiturates</p> <p><input type="checkbox"/> Heroin <input type="checkbox"/> Other _____</p> <p><input type="checkbox"/> Ecstasy</p> <p><input type="checkbox"/> Never Used</p> <p>If a former user, what year did you quit?</p> <p>_____</p>
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Other Social History Not Listed Above:

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