Kidney Associates of Texas
Excellence in Kidney Care

McKinney Office: 4510 Medical Center Drive, Suite 202, McKinney, TX 75069

Sherman Office: 300 N Highland Ave, Suite 365, Sherman, TX 75092

Phone: 972-521-6000, Fax: 972-521-6012
www.kaotexas.com

HEALTH HISTORY FORM

Name: …… **SSN** ……. ☐ **Male** ☐ **Female**

Address: ……**City:** …… **State:** …….. **Zip:** ……

Age: …… **DOB:** ……..**Phone:** ……..……**Alternate Phone:** ……

OTHER PHYSICIANS YOU SEE

Name …… Specialty ……
Name …… Specialty ……
Name …… Specialty ……
Name …… Specialty ……

PAST MEDICAL HISTORY (Please Check mark all that apply)

☐ **High Blood Pressure (Hypertension)** ☐ **Previous Kidney Disease/CKD** ☐ **Stroke/TIA**

☐ **Kidney Stones** ☐ **CHF** ☐ **Heart Disease**

☐ **Diabetes- [ ] Type 1 [ ] Type 2 [ ] Type 2 on Insulin**

[ ] Hearing Problems [ ] Blindness [ ] Cataract [ ] Retinopathy [ ] Right/left [ ] Laser Surgery Right/Left

[ ] COPD [ ] Irregular Heart Beats [ ] Coronary Artery Stent

[ ] Stomach Ulcers [ ] Colon Cancer [ ] Hepatitis [ ] Asthma [ ] Gout [ ] Recurrent Kidney/Bladder Infections

[ ] Prostate Disease [ ] UTI [ ] Epilepsy/Seizures [ ] Thyroid Disease [ ] High Cholesterol

[ ] Rheumatoid Arthritis [ ] Osteoarthritis [ ] Lupus [ ] Skin Disorder

[ ] Osteoporosis [ ] Anxiety [ ] Anemia ([ ] Due to Iron Deficiency [ ] Chronic Kidney Disease [ ] Unknown) [ ] Cancer)

[ ] OTHER: ……..

PAST SURGICAL HISTORY (Please Check mark all that apply)

Surgeries: [ ] None [ ] Appendectomy [ ] AVF/AVG [ ] Coronary Artery Bypass [ ] Transplant

[ ] Cataract Surgery [ ] Gall Bladder [ ] Left Hip Surgery [ ] Right Hip Surgery [ ] Hysterectomy

[ ] Right Knee Surgery [ ] Left Knee Surgery [ ] Kidney

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FAMILY HISTORY

Father: [ ]Living[ ]Deceased [ ]No Significant History[ ]Diabetes[ ]Heart Attack[ ]CHF[ ]Kidney Failure[ ]High Blood Pressure [ ]Cancer[ ]Stroke

Mother: [ ]Living[ ]Deceased[ ]No Significant History[ ]Diabetes[ ]Heart Attack[ ]CHF[ ]Kidney Failure[ ]High Blood Pressure [ ]Cancer[ ]Stroke

SOCIAL HISTORY

Smoking: [ ] Yes [ ] No [ ] Quit When did you quit:_____How many years did you smoke:_____Number of Packs/Day:__

Alcohol: [ ] Yes [ ] No [ ] Social [ ] Heavy [ ] Quit

H/O IV Drug Abuse: [ ] Yes [ ] No

Marital Status: [ ] Married [ ] Single [ ] Widowed [ ] Divorced

Occupation:_____Employment Status: [ ] Full-Time [ ] Part-Time [ ] Retired [ ] Self-Employed [ ] Student

Living With: [ ] Spouse [ ] Family [ ] Alone [ ] Other

CHECK IF YOU EXPERIENCE ANY PROBLEMS

□ Frequent Urination	□ Straining to Urinate	□ Blood in Urine	□ Up at night to urinate often	□ Excess Urination	□ Foamy Urine
□ Burning with Urination	□ Weak Urine Stream	□ Leaky Bladder	□ Kidney Stones	□ Urine smells different	□ Excessive Thirst
□ Nausea and Vomiting	□ Constipation	□ Diarrhea	□ Fever/chills	□ Night Sweats	□ Abdominal Pain
□ Chest pain	□ Palpitation	□ Dizziness or Vertigo	□ Balance Problems	□ Irregular Heart Rate	□ Swelling in hands or feet
□Wheezing	□ Shortness of Breath	□ Persistent Cough	□ Night Sweats	□ Sinus Problems	□ Claudication
□ Bone or Joint Pain	□ Muscle pain or weakness	□ Headaches	□ Leg pain or cramps	□ Nosebleeds	□ Back Pain
□Weight gain	□Weight Loss	□ Headache	□ Confusion	□ Blurry Vision	□ Excess Fatigue

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Pharmacy Name: ……Phone: …….

Allergies to Medications: [ ] No [ ] Yes (if YES please Explain)

……..

Do you take any of following: (Circle what applies to you)

TYLENOL MOTRIN IBUPROFEN ALEEVE NAPROXEN MOBIC HERBALS

YOUR CURRENT MEDICATION LIST

Name Of Medication (as it appears on the Bottle)	**Dosage:**	**How Much Taken:**	**How Many Times Taken Daily:**
(example) Aspirin	81 Mg	1 Tablet	Once a Day