HEALTH HISTORY QUESTIONNAIRE

Ocala Kidney Group

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

Name *(Last, First, M.I.):* ☐ M ☐ F	**DOB:**
Referring doctor:	
Pharmacy:	
Other Current Physicians:	

PERSONAL HEALTH HISTORY

Childhood illness: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio

CIRCLE ANY MEDICAL PROBLEMS THAT OTHER DOCTORS HAVE DIAGNOSED:

Heart Trouble	Cold Sores/Blisters	Frequent Cough	Stroke	Cortisone Treatment
Lung Disease	Glaucoma	Heart Murmur	Diabetes	Fainting or Dizziness
Epilepsy or Seizures	Rheumatic Fever	Excessive Thirst	Liver Disease	Extreme Nervousness
Artificial Joints	Hepatitis A or B	Hypoglycemia	Artificial Heart Valve	Kidney Trouble
Yellow Jaundice	Psychiatric Care	Heart Pacemaker	Ulcers	Chemical Dependency
Cancer	Heart Surgery	Allergies	Thyroid Disease	Blood Transfusion
Blood Disease	Scarlet Fever	Parathyroid Disease	Hemophilia	Anemia
Asthma	Chest Pain	Hay Fever	Chemotherapy	AIDS or HIV Positive
Venereal Disease	Tuberculosis	Sinus Trouble	Arthritis/Gout	Emphysema
Rheumatism	Excessive Bleeding	Shortness of Breath	COPD	Swelling of feet/ankles
Congenital Heart	Blood Pressure	X-Ray/Cobalt Treatment		

List your prescribed drugs and over the counter drugs, such as vitamins and inhalers

Name of Drug	Strength	Frequency Taken

Allergies to medications	
Name the Drug	Reaction You Had

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.						
Alcohol	Do you drink alcohol?				☐ Yes	☐ No
	If yes, what kind?					
Tobacco	☐ Cigarettes – pks./day	☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day		
	☐ # of years	☐ Or year quit				
Drugs	Do you currently use recreational or street drugs?				☐ Yes	☐ No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**	☐ M ☐ F	
Mother				☐ M ☐ F	
Sibling	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**Grandmother** *Maternal*		
	☐ M ☐ F		**Grandfather** *Maternal*		
	☐ M ☐ F		**Grandmother** *Paternal*		
	☐ M ☐ F		**Grandfather** *Paternal*		

OTHER PROBLEMS

Check if you have, or have had, any symptoms in the following areas:

☐ Skin	☐ Chest/Heart	☐ Recent changes in:
☐ Head/Neck	☐ Back	☐ Weight
☐ Ears	☐ Intestinal	☐ Energy level
☐ Nose	☐ Bladder	☐ Ability to sleep
☐ Throat	☐ Bowel	☐ Other pain/discomfort:
☐ Lungs	☐ Circulation	

Please list any **MAJOR** surgeries you have had, such as Heart, Transplant or Kidney: _____

Date: _____ Signature: _____