Advanced Kidney Care P.C.

History & Physical

Name _____ SS # _____ Date _____

Address _____ City _____ State _____ Zip _____ Occupation _____

Phone # _____ Work # _____ DOB _____ Age _____

Chief complaint _____

Drug Allergies

Current Medications

Family History

	Father	Mother	Father's Parents	Mother's Parents	Children	Siblings
Heart Disease						
High Blood Pressure						
Stroke						
Cancer						
Glaucoma						
Diabetes						
Epilepsy/Convulsion						
Bleeding Disorder						
Kidney Disease						
Thyroid Disease						
Mental Illness						
Osteoporosis						

Hospitialization or Surgery

Reason:	Date:

Medical History

	Hypertension		Dizziness/ fainting		Ulcer
	Hyperlipidemia		Anxiety		GI disorder
	Heart palpitations		Fatigue		Sexual dysfunction
	Heart murmur		Shortness of breath		Menstrual dysfunction
	Arrhythmia		Orthopnea		Incontinence
	Chest pain/ Angina		Allergies/ Hay fever		Anemia
	MI		Asthma		Arthritis
	Stroke/ TIAs		COPD		Osteoporosis
	Claudication		Pneumonia		Gout
	Congestive heart Disease		Venereal disease		Diabetes
	Congenital heart disease		Scarlet fever		Endocrine disease
	Headache		Rheumatic fever		Other:
	Epilepsy		Liver disease		Other:

WOMEN ONLY: Pregnant? YES NO Planning Pregnancy? YES NO

MEN ONLY: Do you occasionally experience erection difficulties? YES NO

Smoke: YES NO
Packs Daily:
How Long?
Interested in Stopping? Y / N

Coffee: YES NO
Cups Daily:
Other Caffiene:

Alcohol: YES NO
Type:
Amount:

Sleep:
Difficulty Falling Asleep Y / N
Continuity Disturbances Y / N
Snoring Y / N
Early Morning Awakening Y / N
Day Drowsiness Y / N

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PHYSICAL EXAM (DOCTORS ONLY)

Temperature: _____ Pulse: _____ BP: _____

Height: _____ Weight: _____ Respiration: _____

General Appearance: _____

_____

	N	AB	Notes:
Skin			
HEENT			
Neck			
Thyroid			
Lymph nodes			
Veins/carotid			
Chest			
Lungs			
Heart			
Abdomen			
Genital			
Rectal			
Extremities			
Joints			
Clubbing/cyanosis			
Peripheral pulses			
Edema			
Neurologic			

IMPRESSIONS

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