NY HEALTH KIDNEY SPECIALISTS
Nephrology & Hypertension Specialists
2500 Nesconset Highway, Bldg. #14A
Stony Brook, NY 11790
Tel: (631) 689-7800
Fax: (631) 689-3016
nyhealth.com

PATIENT'S HEALTH HISTORY FORM

Dear Patient please fill in both page 1, and page 2 (please see over) **Page 1**

Name:_____ **Date :** _____

Date of Birth: _____

Referring M.D.:

_____

_____

Reason for referral:

_____

_____

_____

_____

Other M.D.'s currently seeing: _____

_____

_____

PAST MEDICAL HISTORY
(please check Yes or No)

OTHER MEDICAL CONDITIONS OR DETAILS OF EXISTING CONDITIONS
(please describe in the space below)

	Yes	No		Yes	No	
Diabetes	□	□	Stroke / CVA / TIA	□	□	_____
High Blood Pressure	□	□	Arthritis	□	□	_____
Heart disease	□	□	Cancer	□	□	_____
Heart Attack	□	□	Asthma / COPD	□	□	_____
High Cholesterol	□	□	Congestive heart failure	□	□	_____
Pacemaker / AICD	□	□	Peripheral vascular disease	□	□	_____
Kidney Disease (chronic)	□	□	Blood clots	□	□	_____
Kidney stones	□	□	Acute kidney failure	□	□	_____
Anemia	□	□	Liver Disease	□	□	_____

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PATIENT'S HEALTH HISTORY FORM

PAST SURGICAL HISTORY (please list below important surgeries you had in the past):

_____

_____

_____

Hospitalization (Past Year) Yes ___ No ___ If Yes, name of Hospital:_____

Reason for hospitalization: _____

REVIEW OF SYSTEMS
(please mark YES – Y, if you have any of following symptoms, or NO – N if you do not have symptoms)

Constitutional	**Y**	**N**	**HEENT**	**Y**	**N**	**Respiratory**	**Y**	**N**	**Cardiovascular**	**Y**	**N**
Weight Loss			Decreased vision			Shortness of breath			Chest pain		
Weight Gain			Blurry vision			Cough			Palpitations		
Fever			Diabetic retina disease			Wheezing			Edema/leg swelling		
Chills			Bleeding behind eye			Difficulty breathing			Fainting episodes		
Excessive tiredness			Other			Lung disease			Leaky heart valves		
Gastrointestinal			**Genitourinary**			**Musculoskeletal**			**Skin**		
Nausea			Burning on urination			Joint aches			Itchy skin		
Vomiting			Blood in urine			Joint swelling			Rashes on body		
Poor appetite			Frequent urination			Muscle aches			Dry skin		
Diarrhea			Urinary tract infection			Muscle swelling					
Blood in stool			Kidney stones in past			Pain killer use			**Other Symptoms**		
Neurologic			**Endocrine**			**Hematologic**			**(describe)**		
Confusion			Excess thirst			Easy bruising					
Lightheadedness			Cold Intolerance			Blood clots					
Severe headaches			Heat Intolerance			Bleeding disorder					
Numbness in feet			Large amount urine								

SOCIAL HISTORY: Marital status_____ Occupation_____
Non-smoker (never smoked) _____ Ex-smoker (year quit)_____ Current smoker _____ cigarettes / day_____
Alcohol consumption, occasional _____, frequent_____, never _____
FAMILY HISTORY: (please list any known medical problems)
Father:_____
Mother: _____
Siblings: _____
Your Children: _____
ADDITIONAL INFORMATION: (Use this space to provide any additional information important to your health)

_____ _____
Signature of Reviewing Physician Date Signature of Patient Date

_____
Signature of Nurse Practitioner Date