Northwest Renal Clinic, Inc.

Physicians

CLINICAL REPORT

Date _____

Please Print
Full Name _____ Age _____ Birth Date _____ Where Born _____

Address _____ Home Phone _____ Work Phone _____
STREET

_____ Referred by _____
CITY STATE ZIP

Occupation _____ How long in this type of work _____

REASONS FOR SEEKING MEDICAL ATTENTION NOW: (confidential items need not be stated)

Routine Physical Exam – No Complaints ☐

FAMILY HISTORY NAME	IF LIVING Age	IF LIVING Health	IF DECEASED Age at Death	IF DECEASED Cause	Has any blood relative ever had: (if yes, please circle)
Father					Cancer
Mother					Sugar Diabetes
Brother or Sister:					Heart Disease
1.					High Blood Pressure
2.					Mental Illness
3.					Tuberculosis
4.					Arthritis
5.					Gout
Spouse					Kidney Stone
Children					Migraine Headaches
1.					Blood Disease
2.					Goiter
3.					Stroke
4.					Allergy
5.					Overweight

PERSONAL HISTORY OF YOUR PAST ILLNESSES: Please circle illnesses you have had, and add the date(s).

Rheumatic fever _____
Heart disease _____
or heart murmur _____
High blood pressure _____
Stomach ulcers _____
Anemia _____
Kidney Disease _____
Tuberculosis _____
Pneumonia _____
Venereal Disease _____

Thyroid disease _____
Eye disease _____
Arthritis _____
Hepatitis _____
Liver disease _____
Epilepsy _____
Migraine Headache _____
Diabetes _____
Cancer _____
Nervous Breakdown _____

Asthma or hay fever _____
Deformity _____
Skin trouble _____
Alcoholism _____
Broken bones _____
_____
Head injury _____
Gout _____
Lung condition _____
Other _____

ARE YOU ALLERGIC TO ANY MEDICATIONS? yes _____ no _____

If yes, please list medications, and the reaction you had to them:

_____

_____

_____

Present weight _____ Weight 1 year ago _____ Weight 5 years ago _____ Height _____

What is the most you have weighed (not counting pregnancy)? _____ When? _____

Date _____

SURGERIES

Please list all of your surgeries and hospitalizations:

Date	Surgery or reason for Hospitalization	Where	Doctor
1.			
2.			
3.			
4.			
5.			
6.			

Have you ever been advised to have any surgical operation which has not been done? If yes, please explain

Date of last complete physical exam _____ by Dr. _____ normal or abnormal? _____

X-RAYS

Have you ever had X-rays of

Chest	date	normal or abnormal
Stomach or colon	date	normal or abnormal
Gall Bladder	date	normal or abnormal
Back	date	normal or abnormal
Other	date	normal or abnormal

Have you ever had an Electrocardiogram? (EKG)_____ date: _____ was it normal or abnormal? _____

Have you previously been under the care of another physician for current problems? _____ If so, who? _____

IMMUNIZATIONS: (please give date of last vaccination)

Smallpox _____ DPT _____ Measles _____ Flu _____

Polio _____ Typhoid _____ Tetanus _____ Other _____

SOCIAL:

M _____ W _____ S _____ D _____ If M, W or D, how long? _____

Previous marriages: _____

Any problems with marriage? _____

Religious affiliation: _____

Educational level: Grade School ____ yrs. High School _____ yrs. College _____ yrs. Other _____

Any problems with job? _____

Previous Occupations: _____

When did you come to this region? _____

Former regions of residence: _____

Describe your typical day's activities: _____

HABITS:

Do you use: Cigarettes: _____ packs per day. Cigars _____ Pipe _____ Coffee _____ cups per day. Tea _____ cups per day.

Regular exercise _____

Have you ever used any experimental drugs? Marijuana _____ LSD _____ Speed _____ Heroin _____ Others _____

How much alcohol do you consume in one week? _____

Have you ever used alcohol or medication excessively? _____

MEDICATIONS:

Are you presently taking any medications? Please list:

(Please include heart pills, laxatives, vitamins, antiacids, hormones, insulin and any other medications.)

1. _____	4. _____	7. _____
2. _____	5. _____	8. _____
3. _____	6. _____	9. _____

Date _____

REVIEW OF **RECENT** SYMPTOMS: Please circle any of the following symptoms you have experienced recently.

General:
- chills or fever
- unusual fatigue
- unusual weakness
- abnormal thirst
- unable to sleep
- swollen glands
- weight changes
- appetite poor

Head:
- frequent headache
- dizziness
- loss of balance
- fainting spells

Eyes:
- wear glasses
- wear contact lenses
- blurry vision
- eye pain
- see double

Ears:
- hearing loss
- ringing in ears
- infection or drainage
- earache

Throat:
- wear dentures
- hoarseness
- frequent sore throat
- bleeding gums

Nose
- nose bleeds
- sores

Breasts:
- lump
- pain
- discharge

Heart:
- high blood pressure
- racing or fluttering heart
- chest pain
- shortness of breath
- leg cramps
- swollen feet or ankles

Lungs:
- persistent cough
- coughing up blood
- difficulty breathing
- wheeze
- cough up phlegm

Intestinal:
- difficulty swallowing
- frequent indigestion
- belching
- nausea
- vomiting
- constipation
- loose bowels
- black stools
- change in bowel habits
- hemorrhoids
- abdominal pain

Urinary:
- pain or burning on urination
- night frequency
- day frequency
- slow urine stream
- lose urine with cough or sneeze
- discharge
- sexual difficulty
- blood in urine

Bones & Joints:
- painful or stiff joints
- swelling of joints
- back pain
- numbness or tingling
  - where
- cramps in muscles
- foot trouble

Skin:
- itching
- rash or hives
- bruise easily
- change in mole or wart
- loss of hair

Menstrual: (women)
- last period
- last pap smear
- menstrual pain
- pre-menstrual tension
- spotting
- discharge
- heavy bleeding
- birth control pill

Number of Pregnancies:
- live births
- miscarriages
- abortions
- caesarians
- premature births

Mood:
- lack of memory
- cry often
- depressed
- worry alot
- worried about health
- tense or under stress
- shy or sensitive
- work or family problems
- frightening thoughts
- desired psychiatric help
- considered suicide
- generally happy

Neurologic
- weak muscles
- numbness
- tremor
- trouble walking
- seizures or convulsions

Please sign your name _____ and date _____

Dr. Comments, continued _____