Nephrology Associates of Central Maine

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MEDICAL QUESTIONNAIRE

Your replies to these questions will be held in strict confidence, and will help us make sure that we do not overlook important details in your medical history. Please being this form with you on the day of your appointment.

Name_____ **Date**_____

I. Present Problem: Your main complaint at this time. Explain in your own words your symptoms, their duration, severity, things which make them better or worse and their relationship to other events, etc.

Other Problems: (List, giving duration)
1.
2.
3.
4.
5.

II. General Information

State of health: good fair poor (circle one)

Place of birth and where raised:_____

Date of birth_____ Your Age_____

Education Completed_____

_____

Occupation: (describe nature of work, time job held and any known occupational hazards)

_____

Recreation:

Hobbies_____

Religious Activities_____

Marital Status_____

Children & ages_____

Habits: Smoking: Cigarettes, Pipe, Cigars, Former Smoker, None (circle)

How much_____ How long:_____

Alcohol: No Occasional Frequently

Coffee: _____ Cups per day_____

Regular exercise and type_____

Military Service: Yes No (circle one)

Service illnesses/wounds_____

Areas stationed_____

Travel:

Outside U.S.A. Yes No (circle one)

Where and when_____

Illnesses while traveling_____

III. Past History

Circle those illnesses that you have had: add details below.

Childhood and adult: mumps, measles, mononucleosis, chicken-pox, rheumatic fever, scarlet fever, cholera, kidney disease, Bright's disease, heart disease, liver disease, yellow jaundice, gallbladder attacks, pneumonia, TB, "sugar diabetes, high blood pressure, tumors, cancer, convulsions, seizures, rheumatism, arthritis, ulcers, colitis, hemorrhoids, piles, venereal disease, diverticulosis, emphysema, injuries, broken bones, lacerations, muscular dystrophy, etc.

List the year of your last immunization for:

Influenza____ Polio____ Measles____ Rubella____ Typhoid____ Tetanus____ DPT____

Hepatitis B____ Hemophilus influenza b (Hib)____ Pneumonia (pneumovax)____

PPD (TB skin test) ____ Positive or Negative?

Any other immunizations?_____

IV. List all hospitalizations, surgery and deliveries

Reason Hospitalized	Date	Hospital & City	Doctor

Previous Medical Evaluations: for example: EKG, eye or ear examinations, endoscopy, GI x-rays, chest and joint x-rays, blood tests, diabetes checks, venereal disease screens, or any other special tests or x-rays (Circle and give details and dates below):

Test	Date	Findings (if known)	Doctor/Hospital

Have you ever been turned down for military service, life insurance, or employment for health reasons?

Blood transfusions: Yes No (circle)
Where and when:_____

V. Family History:

		AGE	LIVING	DEAD	CAUSE OF DEATH	MAJOR DISEASES
FATHER						
MOTHER						
BROTHERS AND SISTERS (list in order of age)	SEX					
CHILDREN						

V. Family History (continued)

(Circle any illnesses which have affected any close blood relative)

Cancer, heart disease, mental illness, nervous breakdown, seizures, convulsions, cataracts, dwarfism, bone defects, muscle disease (muscular dystrophy), cerebral palsy, mental retardation, hay fever, asthma, eczema, migraines, color blindness, goiter, diabetes, breast cysts or cancer, pituitary gland problems, adrenal gland problems, TB, sarcoidosis, rheumatic fever, leaking heart valves, heart attacks, high blood pressure, strokes, brain hemorrhage, ulcers, jaundice, kidney stones, skin cancers, tremors, anemia, sickle cell disease, blue babies, Hodgkin's Disease, leukemia, melanoma, female organ cancer, prostate cancer, bone cancer, colon cancer, stomach cancer, brain tumors, others.

VI. Drug Allergies: (List, with date and type of reaction)

_____
_____
_____
_____
_____

VII. List all current medications (anything used in last 3 months)

_____
_____
_____
_____
_____
_____
_____

VIII. REVIEW OF SYSTEMS

A. Current Weight_____ Maximum weight_____ When were you at your maximum weight_____ Weight 1 year ago_____

B. SKIN (indicate "yes" or "no" for each question):

Yes_____No_____ Have you ever seen a dermatologist?
Yes_____No_____ Have you had any changes in color / texture of skin?
Yes_____No_____ Are you bothered by severe itching?
Yes_____No_____ Does your skin often break out in a rash?
Yes_____No_____ Are you often troubled by boils?
Yes_____No_____ Have you ever had skin cancer?
Yes_____No_____ Have you ever had hives?

C. BLOOD

Yes_____No_____ Have you ever been treated for severe anemia?
Yes_____No_____ Do you, or does anyone in your family, have an inherited blood clotting or bleeding disorder?
Yes_____No_____ Do you have any enlarged lymph glands?
Yes_____No_____ Have you ever had a bone marrow test?
Yes_____No_____ Have you ever donated blood? Last donation_____

D. EYES, EARS, NOSE, AND THROAT

Yes_____No_____ Is your eyesight getting worse?
Yes_____No_____ Do you need glasses?
Yes_____No_____ Do you have glaucoma?
Yes_____No_____ Do you have any other eye problems?
Yes_____No_____ Do you ever see double?
Yes_____No_____ Are you hard of hearing?
Yes_____No_____ Have you ever had severe or recurrent ear infections?
Yes_____No_____ Are you frequently dizzy or lightheaded?
Yes_____No_____ Have you ever had mastoiditis or a mastoid operation?
Yes_____No_____ Do you have constant noises in your ear?
Yes_____No_____ Are you often troubled with sneezing spells?
Yes_____No_____ Do you get hay fever?
Yes_____No_____ Is your nose frequently stuffed up?
Yes_____No_____ Do you suffer from a constantly runny nose?
Yes_____No_____ Have you ever had bad nosebleeds?
Yes_____No_____ Do you often catch severe colds?
Yes_____No_____ Do you have false teeth?
Yes_____No_____ Do you have bleeding gums?
Yes_____No_____ Do you have pyorrhea or a chronic gum problem?
Yes_____No_____ Do you often have toothaches?
Yes_____No_____ Does your tongue get sore or burn?
Yes_____No_____ Have you ever had sinusitis?
Yes_____No_____ Do you get frequent sore throats?
Yes_____No_____ Do you frequently get hoarse?

E. HEART AND LUNGS

Yes_____No_____ Do you frequently suffer from chest colds?
Yes_____No_____ Have you ever suffered from asthma?
Yes_____No_____ Are you troubled by chronic coughing?
Yes_____No_____ Do you bring up phlegm? Amount_____? Color?
Yes_____No_____ Have you ever coughed up blood?
Yes_____No_____ Do you sometimes have severe, soaking night sweats?
Yes_____No_____ Have you ever had a chronic chest condition?
Yes_____No_____ Have you ever had pleurisy?
Yes_____No_____ Has a doctor ever said your blood pressure was too high?
Yes_____No_____ Have you ever taken medication for high blood pressure?
Yes_____No_____ Do you have chest pain or discomfort?
Yes_____No_____ Do you get tightness, pressure, squeezing, or burning in the chest after exertion or meals?
Yes_____No_____ Are you bothered by a thumping heart, or palpitations?
Yes_____No_____ Have you ever taken Nitroglycerine under your tongue?
Yes_____No_____ Does your heart ever race?
Yes_____No_____ Do you often have difficulty breathing?
Yes_____No_____ Do you run out of breath long before most others?
Yes_____No_____ Do you ever get short of breath when sitting still?
Yes_____No_____ Do you ever have to sleep sitting up?
Yes_____No_____ Do you use more pillows than you used to?
Yes_____No_____ Do you suffer from frequent leg cramps?
Yes_____No_____ Has a doctor ever said you have heart trouble?
Yes_____No_____ Do you have a heart murmur?
Yes_____No_____ Do you have an enlarged heart?
Yes_____No_____ Have you ever had rheumatic fever?
Yes_____No_____ Do you have varicose veins?
Yes_____No_____ Do you get severe pain in your legs when walking?
Yes_____No_____ Do your feet or ankles ever get swollen?

F. DIGESTIVE SYSTEM

Yes_____No_____ Is your appetite excessive?
Yes_____No_____ Is your appetite poor?
Yes_____No_____ Do you often suffer from an upset stomach?
Yes_____No_____ Is it difficult or painful for you to swallow?
Yes_____No_____ Do you usually feel bloated after eating?
Yes_____No_____ Do you usually belch a lot after eating?
Yes_____No_____ Do you have frequent heartburn?
Yes_____No_____ Do you suffer from indigestion?
Yes_____No_____ Do you have severe stomach pains?
Yes_____No_____ Have you ever vomited blood?
Yes_____No_____ Do you suffer from constant stomach troubles?
Yes_____No_____ Has a doctor ever said you had a stomach ulcer?
Yes_____No_____ If so, was it found by x-ray examination? When, and where done?_____
Yes_____No_____ Have you ever had blood in your stools?
Yes_____No_____ Are your bowel movements ever black?
Yes_____No_____ Have you had mucus in your stools?
Yes_____No_____ Do you suffer from frequent loose bowel movements?
Yes_____No_____ Have you ever had intestinal worms?
Yes_____No_____ Do you have pain when you move your bowels?
Yes_____No_____ Do you suffer from bad constipation?
Yes_____No_____ Have you had a recent change in youe bowel habits?
Yes_____No_____ Have you ever had piles (hemorrhoids)?
Yes_____No_____ Have you ever had jaundice (yellow eyes or skin)?
Yes_____No_____ Have you ever had serious liver or gallbladder trouble?
Yes_____No_____ Has a doctor ever said you had gallstones?

G. URINARY SYSTEM

Yes_____No_____ Were you ever treated for venereal disease?
Yes_____No_____ Do you urinate frequently during the day?
_____ How many times do you get up to urinate at night?
Yes_____No_____ Do you ever have pain or burning when you urinate?
Yes_____No_____ Do you sometimes lose control of your bladder?
Yes_____No_____ Has your urine ever been brown, black, or bloody?
Yes_____No_____ Has your doctor ever said you have kidney or bladder disease?
Yes_____No_____ Have you ever had kidney stones, or kidney colic?
Yes_____No_____ Have you had any problem with sexual function?

H. MEN ONLY

(Women go to the next section):

Yes_____No_____ Have you ever had anything seriously wrong with your genitals?
Yes_____No_____ Have you ever had treatment for your genitals?
Yes_____No_____ Has a doctor ever said you had a hernia or rupture?
Yes_____No_____ Do you ever have trouble starting your urine stream?
Yes_____No_____ Do you have trouble stopping (dribbling)?
Yes_____No_____ Do you have a weak stream?
Yes_____No_____ Do you have a split stream?
Yes_____No_____ Has a doctor ever said you have prostate trouble?
Yes_____No_____ Have you had a vasectomy?

I. FEMALES ONLY

(Men go on to next section)

Last Pap Smear done?_____
Age you started your period?_____
Yes_____No_____ Have you ever had an abnormal Pap Smear?
Yes_____No_____ Are your periods regular?
How far apart are your periods?_____
How many days do they last?_____
Is the flow excessive, normal, scanty? (circle one)
What do you use for contraception?_____
Other methods of birth control used in the past?_____
Date of last menstrual period_____
Date of period before that_____
If past menopause, date of menopause_____
Number of pregnancies_____ Number of children_____Number of miscarriages_____
Yes_____No_____ Do you commonly pass clots with your period?
Yes_____No_____ Do you have discomfort with your periods?
Yes_____No_____ Do you ever bleed between periods?
Yes_____No_____ Do you ever have hot flashes, or other menopausal symptoms?
Yes_____No_____ Have you ever taken female hormones?
Yes_____No_____ Have you ever had vaginal bleeding since menopause?
Yes_____No_____ Do you ever have any vaginal discharge?
Yes_____No_____ Have you ever had any lumps or tumors in your breasts?
Yes_____No_____ Have you ever had blood or discharge from your nipples?
Yes_____No_____ Are your breasts ever painful or tender?
Date of last mammogram_____

J. BONES AND JOINTS

Yes_____No_____ Are your joints ever painfully swollen?
Yes_____No_____ Do your joints and muscles often feel stiff or hot?
Yes_____No_____ Do you have severe pain in your arms or legs?
Yes_____No_____ Do you have severe pain in your back or neck?
Yes_____No_____ Does rheumatism (arthritis) run in your family?
Yes_____No_____ Does back pain make it hard for you to keep up with your work?
Yes_____No_____ Have you ever had sciatica or lumbago?
Yes_____No_____ Do you ever have muscle weakness?
Yes_____No_____ Do you have any muscle tenderness?
Yes_____No_____ Do you have a serious bodily disability or deformity?

K. GENERAL

Yes_____No_____ Do you suffer from any chronic disease?
Yes_____No_____ Do you frequently have severe headaches?
Yes_____No_____ Have you ever been treated for a tumor or cancer?
Yes_____No_____ Do you have spells of severe dizziness?
Yes_____No_____ Do you frequently feel faint?
Yes_____No_____ Have you fainted more than twice in your life?
Yes_____No_____ Do you have constant numbness or tingling in any part of your body?
Yes_____No_____ Has any part of your body ever been paralyzed, even partially?
Yes_____No_____ Have you ever been knocked unconscious?

Yes_____No_____ Have you ever had twitching of the hands, face, or shoulders?
Yes_____No_____ Have you ever had a stroke?
Yes_____No_____ Have you ever had a "fit" or convulsion (epilepsy)?
Yes_____No_____ Do you ever get spells of complete exhaustion or excessive fatigue?
Yes_____No_____ Do you have frequent crying spells?
Yes_____No_____ Does working tire you out completely?
Yes_____No_____ Do you have a tendency to be shy or sensitive?
Yes_____No_____ Do you usually wake up tired and exhausted?
Yes_____No_____ Do you have difficulty sleeping at night?
Yes_____No_____ Do you get depressed easily?
Yes_____No_____ Have you ever seriously considered suicide?
Yes_____No_____ Do you worry too much?
Yes_____No_____ Are you nervous?
Yes_____No_____ Have you ever been hospitalized for your nerves?
Yes_____No_____ Do you have spells of difficulty taking a deep breath?
Yes_____No_____ Do you ever get numbness around your mouth or in your fingers?
Yes_____No_____ Do you have memory loss?
Yes_____No_____ Have you ever sought, or wanted to seek, psychiatric help?

L. GLANDS

Yes_____No_____ Do you have diabetes?
Yes_____No_____ Has a doctor ever said you had gland trouble?
Yes_____No_____ Has a doctor ever said you had thyroid trouble?
Yes_____No_____ Do you prefer hot weather?
Yes_____No_____ Do you prefer cold weather?
Yes_____No_____ Do you urinate more than you used to?
Yes_____No_____ Do you drink more liquids than you used to?
Yes_____No_____ Have you had any changes in your hair growth?

Date_____ Reviewed by _____

Date_____ Reviewed by _____

Date_____ Reviewed by _____

Date_____ Reviewed by _____

Date_____ Reviewed by _____