Texas Institute for KIDNEY AND ENDOCRINE DISORDERS (TIKED)

HEALTH HISTORY QUESTIONAIRE

Please complete this entire questionnaire. It will provide us with important information about your health. All answers contained in this questionnaire are strictly confidential and will become part of your medical record.

Name_______________ Male___ Female___ **Date of Birth** _______________

Reason for today's visit_______________ Referring Provider_______________

Occupation (or prior occupation) _______________ Employer_______________

Retired___ Unemployed___ Leave of Absence___ Disabled___ Years education/highest degree______

Marital Status: Single___ Married___ Divorced___ Widowed___ Other___

Spouse/partner's Name _______________ Number of Children _______________

REVIEW OF SYSTEMS: Please indicate any persistent symptoms you have had in the past few months.

GENERAL

___ Unexplained Weight Loss/Gain
___ Unexplained Fatigue/Weakness
___ Difficulty Sleeping
___ Fever, Chills

SKIN

___ Hair Dryness/Loss
___ Rash/Itching
___ New or Change in Mole

BREAST

___ Breast Lump/Pain/Nipple Discharge
___ Skin Changes

EAR/NOSE/THROAT

___ Hearing Loss/Ringing in Ears
___ Nosebleeds
___ Frequent Sore Throat
___ Trouble Swallowing
___ Hoarseness
___ Enlarged Thyroid Gland

RESPIRATORY

___ Cough/Wheeze
___ Loud Snoring
___ Short of Breath w/ Exertion

GASTROINTESTIONAL

___ Heartburn/Reflux/ Indigestion
___ Appetite Changes
___ Nausea/Vomiting
___ Increased Frequency of Bowel Movement
___ Constipation
___ Abdominal Pain

GENITOURINARY

___ Leaking Urine
___ Blood in Urine
___ Discharge
___ Nighttime Urination or Increased Frequency
___ Concern w/ Sexual Function

ENDOCRINE

___ Heat/Cold Sensitivity
___ Excessive Sweating
___ Increased Thirst

HEMATOLOGIC

___ Easy Bruising
___ Easy Bleeding

NEUROLOGIC

___ Headache
___ Fainting
___ Dizziness
___ Numbness/tingling
___ Unsteady Gait
___ Frequent Falls
___ Seizures

PSYCHIATRIC

___ Anxiety/Irritability
___ Depression

EYES

___ Change in Vision
___ Eye Pain
___ Redness

CARDIOVASCULAR

___ Chest Pain/Discomfort
___ High Blood Pressure
___ Palpitations (Fast/Irregular Heartbeat)
___ Bradycardia (Slow Heartbeat)

MUSCULOSKETAL

___ Neck Pain
___ Back Pain
___ Muscle Weakness/Pain
___ Joint Pain/Stiffness
___ Instability
___ Swelling
___ Redness

___ Difficulty Concentrate
___ Sleep Problems

WOMEN ONLY

Age at Onset Menstruation ________________ Date of Last Menstruation________________ Period every _____ days

Do you have heavy periods, irregularity, spotting, pain, or discharge? Yes___ No ___

Do you have menstrual tension, pain, bloating, or irritability at or around time of period? Yes___ No___

Are you pregnant or breast-feeding? Yes___ No___

Number of Pregnancies ___ Number Live Births ___ Number Miscarriages/Abortions ___ Stillbirths___

Complications During Pregnancy ____

Have you had a D&C, Hysterectomy, or Cesarean Section? Yes___ No___

Have you had any urinary tract, bladder, or kidney infections within the last year? Yes ___ No ___

Have you had any blood in your urine? Yes ___ No___

Have you had any problems with control of urination? Yes ___ No ___

Have you had hot flashes or sweating at night? Yes ___ No ___

Last pap smear or pelvic exam _________________________________ Result _____________________________

Do you perform monthly breast self-exams? Yes ___ No ___

Have you experienced any recent breast tenderness, lumps, or nipple discharge? Yes ___ No ___

Last Mammogram __________________________ Where was it done? ___________________ Results ________________

Do you usually get up to urinate during the night?	Yes ___	No ___
Do you feel pain or burning with urination?	Yes ___	No ___
Have you noticed any blood in urine?	Yes ___	No ___
Do you feel burning discharge from penis?	Yes ___	No ___
Has the force of your urination decreased?	Yes ___	No ___
Have you had any kidney, bladder, or prostate infections within the last 12 months?	Yes ___	No ___
Do you have any problems emptying your bladder completely?	Yes ___	No ___
Have you had any difficulty with erection or ejaculation?	Yes ___	No ___
Have you had testicle pain/swelling?	Yes ___	No ___

MEN ONLY

Last Prostate and Rectal Exam ____ Results ___________________

PAST MEDICAL HISTORY: Please indicate if you have a history of the following **(INCLUDE Date of Diagnosis).**

Alcohol Abuse	___	Depression	___	Migraines	___
Anemia	___	Diabetes	___	Osteopenia/Osteoporosis	___
Anesthetic Complication	___	Growth/Develop Disorder	___	Prostate Problems	___
Anxiety Disorder	___	Hearing Impairment	___	Reflux/GERD	___
Arthritis	___	Heart Attack	___	Seizures	___
Asthma	___	Heart Disease	___	Severe Allergy	___
Autoimmune Problems	___	Hepatitis	___	STDs	___
Birth Defects	___	High Blood Pressure	___	Skin Problems	___
Bladder Problems	___	High Cholesterol	___	Stroke/CVA	___
Bleeding Disorders	___	HIV/AIDS	___	Suicide Attempt	___
Blood Clots	___	Hives	___	Thyroid Problems	___
Blood Transfusion (s)	___	Kidney Disease	___	Ulcer	___
Bowel Disease	___	Liver Disease	___	Vision Problems	___
Breast Cancer	___	Lung/Respiratory Disease	___	Other	___
Cancer (Other)	___	Mental Illness	___		

PAST SURGICAL HISTORY:

PROCEDURE	REASON	DATE

SERIOUS ILLNESS/INJURIES:

____

MEDICATIONS: Please bring all bottles/ containers or your own printed record of ALL Prescriptions & Non-Prescription medications, vitamins, home remedies, birth control pills, herbs, inhalers, etc.

ALLERGIES & REACTION: ____

IMMUNIZATIONS & DATE: TETENAUS/DIPHTHERIA/PERTUSSIS (Tdap) _________ Pneumovax ___________

Varicella Shot/Illness _____________ Influenza _____________ Zostavax _____________Tuberculin Skin Test ______________

HEALTH MAINTENANCE SCREENING TESTS:

Sigmoidoscopy or Colonoscopy Date: _____________________ Result ____

Bone Density Scan (DEXA Scan) Date: _____________________ Result ____

Texas Institute for KIDNEY AND ENDOCRINE DISORDERS

Women (Only)

Mammogram Date:_______________________________________ Result __________________________

Pap Smear/ Pelvic Exam Date: ______________________________ Result __________________________

OTHER HEALTH ISSUES:

Tobacco Use –

Do you smoke or have you ever smoked? Yes ___ No ___

Other Tobacco: Pipe ___ Cigar___ Snuff ___ Chew ___

Current Smoker: Approx. how many packs a day do you smoke? How long have you been smoking? ___________

Previous Smoker: When did you quit? ______________________ How many years did you smoke? ___________

Approx. how many packs a day did you smoke? ______________________________

Alcohol Use –

Do you drink alcohol? Yes___ No___

Number drinks per week? ________ Beer______ Wine______ Liquor______

Recreational Drugs –

Do you use marijuana or other recreational drugs? Yes ____ No ____

Have you ever used needles to inject drugs? Yes ___ No ___

Caffeine Use

None ____ Coffee ____ Tea ____ Cola ____ Number of cups/cans per day? _______________

FAMILY MEDICAL HISTORY: Please indicate which RELATIVE has had the following diseases:

I am adopted and do not know biological family history___ Family History Unknown ___

Alcohol Abuse	_________________	Depression	_________________	Osteopenia/ Osteoporosis	_________________
Anemia	_________________	Diabetes	_________________	Seizures/ Convulsions	_________________
Anesthetic Complication	_________________	Heart Attack	_________________	Severe Allergy	_________________
Arthritis	_________________	High Blood Pressure	_________________	Stroke/CVA	_________________
Asthma	_________________	High Cholesterol	_________________	Thyroid Problems	_________________
Bladder Problems	_________________	Kidney Disease	_________________	None of the Above	_________________
Bleeding Disorders	_________________	Leukemia	_________________	Other	_________________
Breast Cancer	_________________	Lung/Respiratory	_________________		
Cancer (Other)	_________________	Migraines	_________________		

Notes:

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Patient's Signature: ____ **Date:** _________________________