CAPITAL NEPHROLOGY

Health information
Medical History

1. **HISTORY OF DIABETES** Yes_____ No_____

   If yes, any:

   Eye problems from Diabetes Yes_____ No_____

   High Blood Pressure Yes_____ No_____

   Arthritis How Long_____

   High Cholesterol Yes_____ No_____

   Kidney Stones Yes_____ No_____

2. **DO YOU HAVE ANY?**

   Blood in Urine Yes_____ No_____

   Difficulty passing Urine: Yes_____ No_____

   Frequent Urination Yes_____ No_____

   Bubbles in urine Yes_____ No_____

   Swelling in Legs Yes_____ No_____

   Shortness of breath on walking Yes_____ No_____

   Shortness of breath at Night Yes_____ No_____

   Chest Pain Yes_____ No_____

   Nausea / Vomiting Yes_____ No_____

   Reduced Appetite Yes_____ No_____

   Weight Loss (Unintentional) Yes_____ No_____

   Muscle Cramps Yes_____ No_____

   Muscle Pains Yes_____ No_____

   Feeling unusually cold Yes_____ No_____

   Fatigue Yes_____ No_____

3. DO YOU TAKE ANY?

   Advil Yes_____ No_____

   Motrin Yes_____ No_____

   Aleve Yes_____ No_____

   Ibuprofen Yes_____ No_____

   Indomethacin Yes_____ No_____

   Nutritional Supplements Yes_____ No_____

4. FAMILY HISTORY OF:

   Diabetes Yes_____ No_____

   High Blood Pressure Yes_____ No_____

   Kidney Disease Yes_____ No_____

Allergies
