ARIZONA TRANSPLANT ASSOCIATES, PC

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MEDICAL HISTORY FORM

PLEASE COMPLETE ENTIRE BUBBLE SHEET **(PAGE 1 of 2)**

SCANNED

(Office use only)

PATIENT NAME:_____ **DOB:**_____

PLEASE FILL IN BUBBLE COMPLETELY (BLACK INK ONLY): EXAMPLE ●

DO NOT ALTER PRE-POPULATED FORM – USE "OTHER" TO ADD COMMENTS, ETC

PERSONAL MEDICAL HISTORY

HAVE YOU HAD A DIAGNOSIS OF: *(multiple choice)*

- O **NONE**
- O Chronic Obstructive Pulmonary Disease (COPD)
- O Congestive Heart Failure (CHF)
- O Coronary Artery Disease (CAD)
- O End-Stage Renal Disease (ESRD)
- O Gastroesophageal Reflux Disease (GERD)
- O Hepatitis C
- O Diabetes, Type I
- O Diabetes, Type II
- O Hypercholesterolemia (HIGH CHOLESTEROL)
- O Hypertension (HIGH BLOOD PRESSURE)
- O Kidney Disease
- O Liver Disease
- O Lung Disease
- O Pancreas Disease
- O Cancer – Type:_____
- O **Other**_____

FAMILY HISTORY

O **ADOPTED**

Does your FATHER have a history of:

O Kidney Disease O Liver Disease O Pancreas Disease O **Other**_____ O **Unknown/None**

Does your MOTHER have a history of:

O Kidney Disease O Liver Disease O Pancreas Disease O **Other**_____ O **Unknown/None**

SURGICAL/HOSPITALIZATION HISTORY

LIST BELOW O ***NONE***

_____ _____ _____

_____ _____ _____

_____ _____ _____

PERSONAL REVIEW OF SYMPTOMS

HAVE YOU EXPERIENCED ANY OF THE FOLLOWING SYMPTOMS? *(multiple choice)*

- O **NONE**
- O Abdominal Pain
- O Bleeding or Bruising Tendency
- O Blood in Urine
- O Blurred or Double Vision
- O Chronic or Frequent Coughs
- O Diabetes (insulin dependent)
- O Diabetes (non-insulin dependent)
- O Difficulty Walking
- O Excessive Thirst
- O Fatigue
- O Frequent Urination
- O Hearing Loss/Ringing in Ears
- O Heat or Cold Intolerance
- O Joint Stiffness or Swelling
- O Lightheaded or Dizziness
- O Memory Loss or Confusion
- O Nausea or Vomiting
- O Numbness or Tingling Sensation
- O Painful Bowel Movements or Constipation
- O Prolonged Bleeding
- O Rash or Itching
- O Recent Weight Change
- O Shortness of Breath
- O Skin Discoloration
- O Sore Throat or Voice Change
- O **Other**_____
- O Claudication and/or Cool Extremities and/or Leg/Foot Pain

HISTORY OF SKIN REACTION OR OTHER ADVERSE REACTION TO:

- O Penicillin or Other Antibiotics
- O Morphine/Demerol/or Other Narcotics

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MEDICAL HISTORY FORM

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SOCIAL HISTORY

TOBACCO/SMOKING USE - Are you a: *(select **ONE**)*

O current smoker O Smoker O nonsmoker
O current every day smoker O current status unknown O unknown if ever smoked
O current some day smoker O former smoker O **Other**_____

If "current smoker": How many cigarettes a day do you smoke? *(select **ONE**)*

O 5 or less O 6-10 O 11-20 O 21-30 O 31 or more

If "current smoker": Are you interested in quitting? *(select **ONE**)*

O Ready to quit O Thinking about quitting O Not ready to quit

ALCOHOL USE:

Did you have a drink containing alcohol in the past year? *(select **ONE**)* O Yes O No

If yes: How often did you have a drink containing **alcohol** in the past year? *(select **ONE**)*

O Never O 2 to 4 times a month O 4 or more times a week
O Monthly or less O 2 to 3 times a week

If yes: How many drinks did you have on a **typical day** when you were drinking in the past year? *(select **ONE**)*

O 1 or 2 drinks O 3 or 4 drinks O 5 or 6 drinks O 7 to 9 drinks O 10 or more drinks

TRANSPLANT PATIENTS LIVER - HISTORY OF LIVER PROBLEMS

O ***NONE***

Have you had a liver transplant? O No O Yes, when?_____
Have you ever been jaundiced? O No O Yes, when?_____
Any travel outside the United States? O No O Yes, where?_____
Have you had any signs of internal bleeding? O No O Yes

TRANSPLANT PATIENTS KIDNEY – HISTORY OF KIDNEY PROBLEMS

O ***NONE***

Have you had a kidney transplant? O No O Yes, when?_____
Do you use peritoneal dialysis (CAPD)? O No O Yes, for how long?_____
Do you use hemodialysis? O No O Yes, for how long?_____
What is your dialysis schedule? O Monday/Wednesday/Friday O Tuesday/Thursday/Saturday

ALLERGIES & REACTIONS LIST ALL ALLERGIES BELOW

O ***NO ALLERGIES***

_____ _____ _____
_____ _____ _____
_____ _____ _____

CURRENT MEDICATIONS LIST ALL MEDICATIONS BELOW

O ***No Medications***

_____ _____ _____
_____ _____ _____
_____ _____ _____