Kidney Associates Medical History Form
Please complete entirely and bring to appointment

Name: _____ Date of Birth: _____
Address: _____Social Security #_____
Phone #_____Cell phone # _____
Emergency Contact Name: _____Phone #_____
Referring Physician: _____ Primary Care Physician: _____
Other Specialty Physicians: _____

Past Medical History:

Medical Conditions	Yes	No	Onset	Physician treating Condition
Anemia (low blood count)				
Diabetes (sugar)				
Diabetes affecting nerves				
Diabetes affecting eyes				
Diabetes affecting organs				
High Blood Pressure				
Heart Attack				
Irregular Heart Rhythm				
Congestive Heart Failure				
High Cholesterol				
Stroke				
Peripheral Vascular Disease				
Kidney Disease				
Kidney Failure				
Kidney Stones				
Kidney Infections				
Bladder Infections				
Lung Disease				
Liver Disease				
Emphysema/COPD/Sleep Apnea				
Arthritis				
Cancer				
If yes which type of Cancer?				
Did you receive radiation or chemo?				

Please list any medical conditions not listed above: _____
_____
Do you use any nonsteroidal medications such as Celebrex, Mobic, Indocin, Aleve, Motrin, or ibuprofen?
If yes, please list medication and how often it is taken _____
When was the last time the medication was taken? _____

Surgical History:
Please list all surgeries: _____
_____
_____
_____

Please list any hospitalizations, ultrasounds or CT scans that have occurred within the past year, please include the location._____
_____
_____
_____

Social History:
Marital Status: _____ Occupation: _____

Do you currently or have previously used tobacco products? Yes or No
Which type of tobacco products do you use and how often do you use them?
_____
How many years have you used tobacco products? _____
If you are a former tobacco product user, when did you quit? _____
Do you use alcohol? Yes or No
How much alcohol do you consume and how often? _____
Do you consume caffeine? Yes or No
How much caffeine do you consume on a daily basis? _____

Family History:

Family Member	Age	Living	Deceased	Medical History
Father				
Mother				
Sibling				
Sibling				
Sibling				
Sibling				
Sibling				
Sibling				
Sibling				

Do you have any family members with kidney disease or on dialysis? Yes or No

Please list all prescribed medications, over-the-counter medications and supplements

Medication	Dose	How many times a day	Prescribing Doctor

Please list all medication allergies and the type of reaction: _____
_____
_____

Pharmacies:
Local pharmacy: _____
Mail order pharmacy: _____

Please remember to bring your insurance cards along to your appointment.