Kidney and Hypertension Specialists, PLLC
Medical History

Name:_____ **Date :** _____

Date of Birth: _____

Referring MD: _____

Reason for referral: _____

Drug Allergies: _____

Please check box for positives, add year for any past surgery

Past Medical History

☐ Allergies	☐ Blood clots	☐ Gallbladder disease	☐ Myocardial infarction
☐ Anemia	☐ Cancer	☐ GERD	☐ Osteoarthritis
☐ Angina	☐ Cerebrovascular accident	☐ Hepatitis C	☐ Osteoporosis
☐ Anxiety	☐ COPD	☐ Hyperlipidemia	☐ Peptic ulcer disease
☐ Arthritis	☐ Coronary artery disease	☐ Hypertension	☐ Renal disease
☐ Asthma	☐ Crohn's disease	☐ Irritable bowel disease	☐ Seizure disorder
☐ Atrial fibrillation	☐ Depression	☐ Liver disease	☐ Thyroid disease
☐ Benign prostatic hypertrophy	☐ Diabetes	☐ Migraine headaches	

Past Surgical History

☐ Angioplasty		☐ Colectomy		☐ Pacemaker	
☐ Angio w/ stent		☐ Colostomy		☐ Small bowel resection	
☐ Appendectomy		☐ Gastric bypass		☐ Thyroidectomy	
☐ Arthroscopy knee		☐ Hernia repair		☐ Tonsillectomy	
☐ Back surgery		☐ Hip replacement		**Gender Specific**	
☐ CABG		☐ Knee replacement		☐ Prostate biopsy	
☐ Carpal tunnel release		☐ LASIK		☐ TURP	
☐ Cataract extraction		☐ Liver biopsy		☐ Vasectomy	
☐ Cholecystectomy		☐ ORIF			

SOCIAL HISTORY: Marital status_____Occupation_____
Primary Language: _____
Non-smoker (never smoked) _____ Ex-smoker (year quit)_____
Current smoker _____ cigarettes / day_____ Years Used _____ Ever tried to quit? _____
Passive smoke exposure: _____
Alcohol consumption, occasional _____ frequent_____ never _____
Caffeine: Yes ☐ No ☐

FAMILY HISTORY: (please list any known medical problems)

Father:_____

Mother: _____

Siblings: _____

Preferred Pharmacy: _____

ADDITIONAL INFORMATION:
(Use this space to provide any additional information important to your health)

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