

Kidney and Hypertension Specialists, PLLC

Medical History Female

Name: _____ Date : _____

Date of Birth: _____

Referring MD: _____

Reason for referral: _____

Drug Allergies: _____

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

Past Histories

Past Medical History

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

Past Surgical History

<input type="checkbox"/> Angioplasty	<input type="checkbox"/> Colectomy	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> D and C
<input type="checkbox"/> Angio w/ stent	<input type="checkbox"/> Colostomy	<input type="checkbox"/> Small bowel resection	<input type="checkbox"/> Hysterectomy
<input type="checkbox"/> Appendectomy	<input type="checkbox"/> Gastric bypass	<input type="checkbox"/> Thyroidectomy	<input type="checkbox"/> Mastectomy
<input type="checkbox"/> Arthroscopy knee	<input type="checkbox"/> Hernia repair	<input type="checkbox"/> Tonsillectomy	<input type="checkbox"/> Myomectomy
<input type="checkbox"/> Back surgery	<input type="checkbox"/> Hip replacement	Gender Specific	<input type="checkbox"/> Reduction mammoplasty
<input type="checkbox"/> CABG	<input type="checkbox"/> Knee replacement	<input type="checkbox"/> Augmentation mammoplasty	<input type="checkbox"/> TAH / BSO
<input type="checkbox"/> Carpal tunnel release	<input type="checkbox"/> LASIK	<input type="checkbox"/> Bilat. tubal ligation	<input type="checkbox"/> Vaginal hysterectomy
<input type="checkbox"/> Cataract extraction	<input type="checkbox"/> Liver biopsy	<input type="checkbox"/> Breast biopsy	
<input type="checkbox"/> Cholecystectomy	<input type="checkbox"/> ORIF	<input type="checkbox"/> Cesarean section	

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: _____