

The Kidney Group

PATIENT INFORMATION

LAST NAME:

FIRST NAME:

M.I.:

D.O.B:

AGE:

SS#:

PLACE OF BIRTH:

REASON FOR VISIT:

PAST MEDICAL HISTORY

LIST ALL MAJOR HOSPITALIZATIONS, SURGERIES, AND ILLNESSES (APPROX. DATE)

CURRENT MEDICATIONS *(INCLUDING OVER-THE-COUNTER DRUGS)*

ALLERGIES:

The Kidney Group

SOCIAL AND FAMILY HISTORY

*** CIRCLE ALL THAT APPLY ***

MARITAL STATUS: S M D W OCCUPATION:

FATHER: ALIVE DECEASED AGE:

MOTHER: ALIVE DECEASED AGE:

SIBLINGS: (AGE AND HEALTH)

CHILDREN: (AGE AND HEALTH)

ANY RELATIVES WITH: KIDNEY DISEASE HEART DISEASE DIABETES

STROKE HYPERTENSION CANCER HIGH CHOLESTEROL

TOBACCO USE: PAST PRESENT TYPE/AMOUNT:

ALCOHOL USE: PAST PRESENT TYPE/AMOUNT:

ADDITIONAL INFORMATION

PLEASE LIST ANY ADDITIONAL INFORMATION YOU FEEL IS PERTINENT FOR THE PHYSICIAN TO KNOW FOR TODAY'S VISIT.
