PATIENT HISTORY FORM

NAME: _____ DOB ____/____/_____ AGE _____ DATE _____

MEDICAL HISTORY

DO YOU HAVE (PLEASE CIRCLE)?

KIDNEY DISEASE:

- Have you ever been told you had kidney disease or had to see a nephrologist or urologist before? No Yes
- Have you ever had a kidney biopsy? No Yes
- Have you ever been told you had blood or protein in your urine before? No Yes
- Have you ever had a kidney stone? No Yes
- Have you ever had surgery on your kidneys, urinary bladder, or prostate? No Yes

DIABETES:

- Have you been told you had diabetes? No Yes
- If so, how long ago was it diagnosed? _____
- Do you take insulin? No Yes
- Do you check your blood sugar? No Yes
- Do you have diabetic eye disease, esp. retinopathy No Yes

HIGH BLOOD PRESSURE:

- Have you ever been told you have High Blood Pressure? No Yes
- If so, how long ago? _____
- Do you take BP medicine? No Yes
- If yes, how long ago was it first prescribed? _____
- Have you ever been hospitalized or in the Emergency room due to high blood pressure? No Yes
- Do you check your BP at home? No Yes
- If so, what are your average BP readings? _____

Please describe if you have had any blood pressure medications you haven't tolerated well or reacted poorly with.

_____

_____

ILLNESSES: PLEASE PLACE A CHECK IF YOU HAVE EXPERIENCED THE FOLLOWING:

Heart Attack	_____	Congestive Heart Failure	_____	Pacemaker/Defibrillator	_____
Chest Pain	_____	Stroke	_____	Seizures	_____
Pneumonia	_____	Chronic Lung Disease	_____	Asthma	_____
Cancer	_____	Liver Disease	_____	Anemia	_____
Blood Transfusion	_____	Depression	_____	Blood Clots/Clotting	_____
Stomach/Intestinal Disorders	_____				