KIDNEY HYPERTENSION TRANSPLANT SPECIALISTS

Kidney Hypertension & Transplant Specialists Medical History Form

Patient Name: _____ DOB: _____

Today's Date: _____

MEDICAL HISTORY

Have you ever been treated by a doctor for any of these medical problems?

High Blood Pressure	☐ No	☐ Yes	Since:
Diabetes	☐ No	☐ Yes	Since:
Kidney Stones/ Cysts	☐ No	☐ Yes	Since:
Proteinuria	☐ No	☐ Yes	Since:
Anemia	☐ No	☐ Yes	Since:
Heart Disease/ CHF	☐ No	☐ Yes	Since:
Stroke/ Heart Attack	☐ No	☐ Yes	Since:
Arthritis	☐ No	☐ Yes	Since:
Osteoporosis	☐ No	☐ Yes	Since:
PVD	☐ No	☐ Yes	Since:
Depression	☐ No	☐ Yes	Since:
Anxiety	☐ No	☐ Yes	Since:
High Cholesterol	☐ No	☐ Yes	Since:
GERD	☐ No	☐ Yes	Since:
Migraine Headaches	☐ No	☐ Yes	Since:
Emphysema	☐ No	☐ Yes	Since:
Asthma	☐ No	☐ Yes	Since:
COPD	☐ No	☐ Yes	Since:

Are you allergic to any medications?

☐ No

☐ Yes If so, please list them below:

_____

_____

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SURGICAL HISTORY

Have you had any of these procedures done?

Amputation	☐ No	☐ Yes	Year:
Appendectomy	☐ No	☐ Yes	Year:
Biopsy C-Section	☐ No	☐ Yes	Year:
Cardiac Stent	☐ No	☐ Yes	Year:
Cataract Removal	☐ No	☐ Yes	Year:
Gastric Bypass	☐ No	☐ Yes	Year:
Pacemaker	☐ No	☐ Yes	Year:
Cholecystectomy	☐ No	☐ Yes	Year:
Hysterectomy	☐ No	☐ Yes	Year:
Vasectomy	☐ No	☐ Yes	Year:
Mastectomy	☐ No	☐ Yes	Year:
Nephrectomy	☐ No	☐ Yes	Year:
Transplant	☐ No	☐ Yes	Year:
Other:_____ Year:_____			

FAMILY HISTORY

Mother
- ☐ Alive
- ☐ Deceased
- ☐ Unknown

Father
- ☐ Alive
- ☐ Deceased
- ☐ Unknown

How many:

Brothers: _____ Sisters: _____ Sons: _____ Daughters: _____

SOCIAL HISTORY

Do you smoke?	☐ No	☐ Yes	☐ Quit	Year:
How often:				
Do you drink alcohol?	☐ No	☐ Yes	☐ Quit	Year:
How often:				
Do you use drugs?	☐ No	☐ Yes	☐ Quit	Year:
How often:				
Do you drink caffeine?	☐ No	☐ Yes	How often:	