The Centers for Kidney Care

Patient Medical History Form

Patient Name ____ Birthday ___________________________

Referring Doctor's Name ____

Chief Complaint that brings you here ____

MEDICATION LIST

Current medications, dosage and frequency. Include over-the-counter medications.		BRING all medications with you to your appointment.
1	6	
2	7	
3	8	
4	9	
5	10	

ALLERGIES

Please list any allergies to any medication, food, x-ray dye, etc.

ILLNESSES

Please note if you have or had any of the following:

	When		When		When
___ Sugar Diabetes	________	___ Asthma	________	___ Prostate Problems	________
___ Kidney Stones	________	___ Hepatitis	________	___ Kidney / Bladder Infections	________
___ High Blood Pressure	________	___ Bladder Problems	________	___ Other Major Illness	________
___ Tuberculosis	________	___ Heart Disease	________		

SURGERIES

Please list previous surgeries and date.

Family History	Living		Deceased	
	Age	Health	Age	Cause of Death
Father				
Mother				
Brother/Sister				
Brother/Sister				
Brother/Sister				
Brother/Sister				
Husband/Wife				
Children				
Children				
Children				
Children				
Children				