KIDNEY AND HYPERTENSION CONSULTANTS, INC.

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PATIENT HISTORY

PATIENT NAME: _____

List Surgeries and Serious Illnesses with Dates: _____

_____

_____

HEART:	YES	NO	paralysis	YES	NO
short of breath			black outs		
able to sleep flat			stroke		
wake up short of breath			**URINARY:**		
heart attack			blood in the urine		
heart pain with exertion			incontinence		
heart murmur			dribbling		
ankle swelling			urinating at night		
ENDOCRINE:			**BLOOD:**		
diabetes			low blood or anemia		
thyroid problem			cancer (if yes, type)		
LUNG:					
tuberculosis			**G.I. TRACT:**		
cough up blood			ulcer		
asthma			bowel habits regular		
emphysema			blood in stool		
pneumonia			liver problems		
NEUROLOGY:			colitis		
numbness			weight loss		

FAMILY HISTORY

RELATIONSHIP	AGE	STATE OF HEALTH	AGE AT DEATH	ILLNESSES CAUSE OF DEATH
Mother				
Father				
	HOW MANY	**STATE OF HEALTH**	**AGE AT DEATH**	**ILLNESSES CAUSE OF DEATH**
Sons/Daughters				
Brothers/Sisters				

ALLERGIES: ____Yes ____ No If yes, please list _____

Do you smoke? ____Yes ____ No
If yes, how much? _____ How many years? _____

Do you drink? ____Yes ____ No If yes, how much and often? _____

Have you noticed any skin rashes? ____Yes ____ No

Is there any kidney disease or blood pressure problems in the family, if so, please indicate which relative _____

_____

Number of pregnancies or miscarriages? _____ Were there any blood pressure problems during pregnancy? _____

LIST ALL MEDICATIONS which you are taking **PLEASE INCLUDE MG AND TIMES TAKEN**

_____

_____

_____

_____