BANERJEE KIDNEY CENTER

Patient History Form

Date_____

Name_____
Date of Birth_____

Primary Care Physician_____

Which doctor referred you here? _____

What is the reason your doctor sent you to see a kidney specialist? _____

_____

_____
How long have you known about this problem?
_____

Check the following that you have/had

____blood in the urine
____protein in the urine
____foamy urine
____kidney stones
____kidney failure
____high blood pressure
____electrolyte imbalance
____abnormal kidney function

Past Medical History

Check the following illnesses that you have/had

____Diabetes
____High blood pressure
____Heart disease
____Heart failure
____Heart valve problem
____Heart murmur
____High cholesterol
____Asthma
____COPD
____GERD
____Sleep Apnea
____Tuberculosis
____Allergies
____Gout
____Vascular disease
____Seizures
____Stroke
____Nerve damage
____Anemia
____Bleeding probs
____Ulcers
____GI bleeding
____Hepatitis
____Gallbladder
____Cancer
____Thyroid disease
____Depression
____Arthritis
____Spine disease
____Osteoporosis

Explain any of the above problems or other medical problems you may have. Include dates and treatments if possible.

_____
_____
_____

List any operations or surgeries

_____
_____
_____
_____
_____
_____

Current Medications-Please provide list
(include over-the-counter medicines—**Tylenol, Advil, Ibuprofen, Aleve, etc.)**

Family Medical History
<u>Which family members have/had</u>:

____Heart disease_____
____Diabetes_____
____High Blood Pressure_____
____KidneyDisease_____
____Stroke_____
____Cancer_____
____Blindness_____
____Deafness_____
Other_____
_____

Social History

___Single____Married____Divorced___Widowed
Occupation_____
Previous occupation_____
With whom do you live? _____
Have you ever smoked? ____YES/how much? _____ NO
Circle which: Cigar Cigarette Vape Marijuana
If so, for how long? _____
When did you quit? _____
Do you drink alcohol? _____
If so, how much? _____
When did you quit? _____

Immunizations—*date/year received if completed*

Pneumovax_____
Fluvaccine_____

Preventative--*date/year performed if completed*

Mammogram_____
Colonoscopy_____
PSA_____

Signature_____

Please List Medications w/Dosages
Include Over the Counter Meds
(Use Another Sheet of Paper if Need Be)

Patient's Name: _____
Date of Birth: _____
ALLERGIES/REACTION: _____
_____
_____

Name of Medication	Dosage/Strength	How Often Taken	Prescriber

Patient's Signature: _____
Date Completed: _____