Texas Kidney INSTITUTE

Personal Medical History

Patient's name:
_____Birthdate:_____

Other Physicians: (attach separate piece of paper if necessary)

1. Name: _____ Telephone number:_____
   Specialty: _____ Fax number:_____
2. Name: _____ Telephone number:_____
   Specialty: _____ Fax number:_____
3. Name: _____ Telephone number:_____
   Specialty: _____ Fax number:_____

Name of Pharmacy: _____ Telephone Number:_____

Address:_____ Fax Number:_____

Social History

Tobacco
☐ No
☐ Yes _____ppd x_____years

Alcohol
☐ No
☐ Yes____Quantity____ Frequency

Illicit Drug Use
☐ No
☐ Yes____Quantity____ Frequency

Advance Directive
☐ No
☐ Yes

Marital Status
☐ Single
☐ Married
☐ Civil Union
☐ Divorced
☐ Widow(er)

Children
☐ Boy(s) Age(s) _____
☐ Girl(s) Age(s) _____

Nutritional/Exercise Assessment

Typical Breakfast
_____

Typical Lunch
_____

Typical Dinner
_____

Usual Snacks/Beverages
_____

Type of Exercise:
_____

Family History — list important medical problems of your parents:

Mother:_____

Father:_____

Any other special medical information:_____

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Personal Medical History

Family History

Mother
☐ Alive, Age ____
☐ Deceased, Age ____ of _____

Father
☐ Alive, Age ____
☐ Deceased, Age ____ of _____

Sister(s)
☐ Alive, Age ____
☐ Deceased, Age ___ of _____
☐ Alive, Age ____
☐ Deceased, Age ___ of _____
☐ Others

Brother(s)
☐ Alive, Age ____
☐ Deceased, Age ____ of _____
☐ Alive, Age ____
☐ Deceased, Age ___ of _____
☐ Others

Notes_____

Drug sensitivity and allergies (describe):_____

Have you ever been told you had one of the following?

Lung disorder	☐yes	☐no	Disease of the kidney	☐yes	☐no
High blood pressure	☐yes	☐no	Diabetes	☐yes	☐no
Heart trouble	☐yes	☐no	Arthritis	☐yes	☐no
Nervous disorder	☐yes	☐no	Hepatitis	☐yes	☐no
Disease or disorder of the digestive tract	☐yes	☐no	Malaria	☐yes	☐no
Any form of cancer	☐yes	☐no			

If answered yes to any of the above, please describe:_____

Disease or disorder of the blood? (describe)_____

Any physical defect or deformity? (describe)_____

Any vision or hearing disorders? (describe)_____

Any life-threatening conditions? (describe)_____

Have you been treated by a physician or been disabled or hospitalized during the last year? (describe)

_____

Have you had or been advised to have a surgical operation within the last five years? (describe)

_____

Signature _____*Date* _____