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)

Typical Breakfast

Typical Lunch

Typical Dinner

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

Usual Snacks/Beverages

Type of Exercise:

Family History — list important medical problems of your parents:

Mother:______________________________________________________________

Father:______________________________________________________________

Any other special medical information:________________________________________
## 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

## Drug Sensitivity and Allergies

Drug sensitivity and allergies (describe):___________________________

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

<table>
<thead>
<tr>
<th>Health Issue</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lung disorder</td>
<td></td>
<td></td>
</tr>
<tr>
<td>High blood pressure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart trouble</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nervous trouble</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disease or disorder of the digestive tract</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Any form of cancer</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*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 ________________

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www.texaskidneyinstitute.com  
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