

PATIENT HISTORY

DATE: _____

NAME _____

DATE OF BIRTH: _____

OCCUPATION _____

PHONE _____

CHIEF COMPLAINT FOR TODAY'S VISIT? _____

ARE YOU ALLERGIC TO ANY MEDICATIONS? (please list) _____

CURRENT MEDICATIONS YOU ARE TAKING _____

WHERE DO YOU TAKE DIALYSIS? _____

WHAT DAYS? _____

PHARMACY _____

PAST MEDICAL HISTORY

	Self	Family	Who?
Asthma			
Bleeding Disorders What type _____			
Cancer What type(s) _____			
Cognitive Heart Failure			
COPD			
Diabetes			
Heart Attack / M I			
Hepatitis A? B? C?			
High Blood Pressure			

	Self	Family	Who?
HIV			
Kidney Problems			
MRSA			
Seizures			
Stroke / CVA			
Thyroid			
Other _____			

OTHER ILLNESSES _____

WHAT SURGERIES HAVE YOU HAD? _____

PERSONAL HABITS:

SMOKE YES _____ NO _____ HOW MUCH A DAY?

ALCOHOL YES _____ NO _____ HOW MUCH A DAY?