**Kidney FL**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

**Medical History**

Please indicate if patient or family member has history of any of the following medical conditions.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  Problem |  Patient |  Father |  Mother |  Sibling (specify) |
| Anemia |  |  |  |  |
| Coronary Artery Disease |  |  |  |  |
| Cancer(specify) |  |  |  |  |
| Diabetes Mellitus |  |  |  |  |
| Heart Disease |  |  |  |  |
| High Blood Pressure |  |  |  |  |
| High Cholesterol |  |  |  |  |
| Kidney Stones |  |  |  |  |
| Kidney Disease |  |  |  |  |
| Stroke |  |  |  |  |

Other medical conditions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Past Surgical History: No \_\_\_\_ Yes\_\_\_\_\_ If yes list procedures and dates: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List all allergies below (including medication, environmental and\or food allergies): No Allergies\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently using tobacco products? No\_\_\_\_\_ Yes\_\_\_\_\_ If yes, quantity per day \_\_\_\_\_\_\_\_\_\_\_\_

If you quit, how often did you use per day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_ For how long: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you drink alcohol? No\_\_\_\_\_ Yes\_\_\_\_\_ If yes, amount: \_\_\_\_\_\_\_\_\_\_\_\_\_ How often: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Influenza Vaccine? Yes\_\_\_\_\_ No\_\_\_\_\_ When:\_\_\_\_\_\_\_\_\_\_ Pneumonia Yes\_\_\_\_\_ No\_\_\_\_\_\_ Date:\_\_\_\_\_\_

**Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**