



NAME: _____ **DOB:** _____

PRIOR MEDICAL PROBLEMS: (Circle all that apply)

Heart Procedures: Stents Bypass Valve Surgery Pacemaker

Gallbladder removal

Appendix removal

Hysterectomy (uterus removal)

Kidney stones

Kidney surgery: _____

Cancer: _____

FAMILY HISTORY:

Does anyone in your immediate family (parents, siblings, children) have the following:

Diabetes (Type I or II): _____

High blood pressure: _____

Heart disease: _____

Stroke: _____

Kidney Problems: _____

Close friend or family member currently or previously on dialysis: _____

Do you currently smoke? YES or NO. If yes how many cigarettes on average per day: _____

Former smoker: Quit. _____ years ago, I smoked _____ cigarettes/day for _____ years _____

Alcohol use: None Rarely/Social 1-2 drinks/day >2 drinks/day

Marital Status: Married Widowed Divorced Single Name of Spouse: _____

Who can we share your medical information with? Spouse Other: _____