Southern IN Nephrology & Hypertension Health Questionnaire Please fill out both sides as completely as you can.

Name:		Date:			
What other Doctors or Providers do you see?		What do you see them for?			
What local ph	armacy do you use?				
Mail order?					
Please list all	allergies you have and what sympton	oms they cau	sed.		
	, ,				
Past Medical	History				
Approximate Date	Medical Condition	Approximate Date	Medical Condition		

Please fill out both sides as completely as you can.

Past Surgi	cal History							
Approximate Date	Procedure	Approximate Date		Procedure				
Date		Date						
Past Social History- please circle and/or fill in blanks								
Marital Stat	us: single married divorced w	idowed ha	ave significa	nt other				
Work Histo	y: currently working retired from	ho	omemaker	unemployed	disabled			
Tobacco Us	se:[]never []current or prior type of to	bacco used_						
amount: # packs per day for years; other quit date								
if currently using: have you ever tried to quit? Y / N would you like information about quitting? Y / N								
		iv Would y		nation about qui	ung: 1714			
	ve you used to try to quit?							
Alcohol or [Orug Use: [] never [] current or prior	type used: _						
amount:	per day for	years	quit da	te				
if curren	tly using: have you ever tried to quit? Y/	N would y	ou like inforn	nation about qui	tting? Y/N			
NSAID use	(meds like Aleve, Ibuprophen, Motrin, Celebrex, et	c): describe h	now taken:		_ for yrs			
Weight: Are	you concerned about your weight or woul	ld you like int	ormation ab	out healthy eatir	ng? Y/N			
Would y	ou like to see a dietitian about healthy eati	ng or help ga	aining or losi	ng weight? Y / I	٧			
Family His	tory- please circle and/or fill in blanks							
Mother: livi	ng, current ageyrs deceased at age _	yrs from	1					
her health	problems:							
Father: living, current ageyrs deceased at age yrs from								
his health	problems:							
Does anyone	e in your family have kidney problems? If yes,	describe						
Does anyone	e in your family have diabetes? If yes, describe	e						
Does anyone	e in your family have high blood pressure? If y	es, describe_						
Has anyone	in your family ever had a heart attack or stroke	e? Other hear	t problems? I	f yes, describe				
Date of last	Flu Vaccine?	Pneumovax?)					
Is there anything else that you think we should know about you?								
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