Shoals Kidney and Hypertension Center
New Patient Information Form

Name _____ **Date** _____ **Referred By** _____

Reason for Visit _____

Please List your Main Medical Problems and Duration of Each

1)_____ **2)** _____ **3)**_____

4)_____ **5)** _____ **6)**_____

7) _____ **8)** _____ **9)**_____

10) _____ **11)**_____ **12)** _____

Please List Your Previous Surgeries with Date

1)_____ **2)** _____ **3)**_____

4)_____ **5)** _____ **6)**_____

Please List your current Medications with doses

Pharmacy: _____ **Phone:** _____

1)_____ **2)** _____ **3)**_____

4)_____ **5)** _____ **6)**_____

7) _____ **8)** _____ **9)**_____

Please List Any Drug Allergies with Reactions

1)_____ **2)** _____ **3)**_____

Social History

Do You Smoke? **NO**____ **YES** ____ **If yes how many packs per day** _____
Do You Drink Alcohol? **NO**____ **YES** ____**If yes how much** _____

Do you Use Any Street Drugs? **NO**____ **YES**____
Marital Status: **Single** ____**Married**____ **Divorced**____ **Other**_____
Occupation: **Retired**____ **Disabled**____ **Working**____ **Other**_____

Place of Employment / How Long _____

Family History: **Please indicate any illness of family members. If deceased, please indicate age and cause**

Father_____ **Mother**_____
Children _____
Siblings_____
Has anyone in your family required Dialysis or Kidney Transplantation? Yes ____ **NO**____