Peninsula Nephrology Associates, P. A.
MEDICAL HISTORY

Date_____

Name: _____ □ Male □ Female Date of Birth: _____

SS #_____ Marital Status □ Married □ Single □ Widowed □ Separated □ Divorced

Ethnicity: □ Caucasian □ African-American □ Asian □ Hispanic □ Native American □ Other

Home #:_____ Wk #:_____ Cell #:_____

Physical Address: _____

City: _____ State:_____ Zip:_____

Emergency Contact:_____ Phone#:_____

E-Mail Address: _____

Primary Care Physician: _____ Phone #: _____

Cardiologist:_____ Phone #: _____

Pharmacy: _____ Location/City: _____ Phone #: _____

Primary Ins Carrier:	Secondary Ins Carrier:
Member/Subscriber ID:	Member/Subscriber ID:
Group # Rx	Group # Rx
Mailing Address:	Mailing Address:
City, State, Zip:	City, State, Zip:
Contact Number:	Contact Number:

Check here if you have had any of the following:For a relative, please list mother, father, sister, brother; child

	YOU	RELATIVE		YOU	RELATIVE
Anemia			HIV/Aids		
Anxiety			Hyperlipidemia		
Arthritis			Hypertension		
Asthma			Kidney/Bladder/Urinary		
Auto Immune Disease			Liver Problems		
Bleeding Problems			Lung Problems		
CAD			Nephrolithiasis		
CHF			Neuropathy		
CKD			Neuromuscular Disease		
Cancer			Retinopathy		
Depression			Seizures/Fits		
Diabetes			Sleep Apnea		
DVT			Stomach, Bowel, GI Problems		
Gout			TB Positive Skin Test		
Hepatitis B or C			Thyroid		
Heart Disease			UTI		
High Blood Pressure					

Social History:
Alcohol: □ never □ socially □ daily □ weekly
Tobacco: □ none
Cigarettes: _____ Packs Per Day:_____ How Many Years _____
Cigars/Pipe_____ Per Day for _____Years

List all medications and dosages taken on a regular basis, including herbal supplements and over the counter:

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Please list all surgeries:

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Please list any known drug allergies:

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