

Name: \_\_\_\_\_

PCP: \_\_\_\_\_

DOB: \_\_\_\_\_

Other Specialists: \_\_\_\_\_

<b><u>Past Medical History (with duration):</u></b>	<b><u>Medications:</u></b>
Diabetes/Diabetic Retinopathy:	
HTN:                      CHF:                      CAD:	
CKD/Previous Baseline Cr:	
Nephrolithiasis:                      Renal Cysts:	
Proteinuria:                      Hematuria:	
Liver Dx:                      Rashes/Joint Pain:	
Recent Abx:                      NSAIDS:	
CT/MRI w/Contrast:                      Renal U/S:	
Vascular Dx:	
Other:	
<b><u>PAST SURGICAL HISTORY:</u></b>	
<b><u>Family Kidney History:</u></b>	
Mom:	<b><u>Social History:</u></b>
Dad:	Tob/ETOH/Illicits:
Siblings:                      Kids:	Employment:
<b><u>Allergies:</u></b>	Residence & Other: