

Allergies - List your allergies including any medications that caused an allergic reaction.

List ALL Allergies	Allergic Reaction

DIALYSIS CENTER TELEPHONE # _____ (if applicable)

Past Major Medical History - Please provide a complete a history including all illnesses and hospitalizations.

List All Major Illnesses	Date	Hospital	Treatment	Physician

Do you have any history of HIV Y N

Past Surgical History - Please provide a complete a history including operations.

List All Operations	Date	Hospital

Prior Surgical Problems

Describe All Problems	Date	Hospital
Anesthesia:		
Wound:		
Bleeding		
Clotting:		
Fever:		
Other:		

Family History - Please list all Blood Relatives with their current health status and any illnesses they have had or have.

List Blood Relatives	Illnesses	Cause of death if deceased
Father		
Mother		
Sibling(s)		

Social History - Please check the appropriate boxes and fill in the accurate amounts of standard portions.

Alcohol: Omit Never Beer(s) _____ Per Week Liquor _____ Per Week _____ Wine Per Week How Many Years: _____
Smoking: Omit Never Current Discontinued Type: _____ Quantity _____ How Many Years: _____
Caffeine: Omit None Cups Per Day: _____ How Many Years: _____ Other: _____