MICHIGAN KIDNEY CONSULTANTS, P.C.
PATIENT HISTORY

To be completed by patient. Please print.

Name Date of Birth

Primary Doctor Referring Doctor

Reason for being referred to Michigan Kidney

Medical History

Have you ever been diagnosed with any of the following medical conditions? Please check all that apply.

CKD	☐	CANCER TYPE _____	☐	GERD	☐	PARKINSONS	☐
TRANSPLANT	☐			STOMACH/BOWEL ULCERS	☐	DEMENTIA	☐
PCKD	☐	STROKE	☐	GALL BLADDER DISEASE	☐	DEPRESSION	☐
DIABETES	☐	GOUT	☐	HEPATITIS	☐	ANXIETY	☐
HIGH BLOOD PRESSURE	☐	COPD	☐	IBS	☐	HYPOTHYROIDISM	☐
HEART ATTACK	☐	CHRONIC BRONCHITIS	☐	PREECLAMPSIA	☐	HYPERTHYROIDISM	☐
ANGINA	☐	ASTHMA	☐	PRENANCY INDUCED HTN	☐	HYPERPARATHYROIDISM	☐
ANGIOPLASTY	☐	EMPHYSEMA	☐	GESTATIONAL DIABETES	☐	ANEMIA	☐
CORONARY STENT	☐	PNEUMONIA	☐	HISTORY OF COMPLICATED	☐	SICKLE CELL DISEASE	☐
CABG	☐	TB	☐	PREGNANCY		BLOOD TRANSFUSION	☐
VALVULAR HEART DISEASE	☐	SLEEP APNEA	☐	OSTEOARTHRITIS	☐	HIV	☐
MITRAL VALVE PROLAPSE	☐	KIDNEY STONES	☐	OSTEOPOROSIS	☐	AIDS	☐
ATRIAL FIBRILLATION	☐	FREQUENT UTI	☐	MULTIPLE SCLEROSIS	☐	RHEUMATOID ARTHRITIS	☐
HIGH CHOLESTEROL	☐	KIDNEY INFECTION	☐	SEIZURES	☐	LUPUS	☐

Pregnancies: Yes ◯ No ◯ How many total? How many were live births?

Surgical History

What surgeries or biopsies have you had? *(Type, Year, Which Hospital if possible)*

Family History

Please list any BLOOD relatives that have/had any of the following conditions *(Mother, Father, Sibling, Child):*

Kidney Disease High Blood Pressure

Diabetes Stroke

Heart Disease Gout

Cancer Dementia/Alzheimer's

Social History

Smoker: Yes ◯ No ◯ Quit ◯ *(What year _____)*

If yes/quit: Cigarettes ☐ Chewing Tobacco ☐ Pipes ☐ Cigars ☐ How many years? _____

Alcohol Use: Current ◯ Never ◯ Quit ◯ *(What year _____)*

If Current/Quit: Occasional/Social ◯ 1-2 drinks/day ◯ 3 or more drinks/day ◯

Recreational Drug Use: Current ◯ Never ◯ Quit ◯ *(What year _____)*

If Current/Quit: Check all that apply.

Marijuana ☐ Heroin ☐ Cocaine ☐ Amphetamines ☐ Ecstasy ☐ Barbiturates ☐ LSD ☐ Opium ☐ Other