

FRESNO NEPHROLOGY MEDICAL GROUP, INC.

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Patient Name: _____

Date: _____

Past Medical History: (Please mark yes if present)

Y	N	Date	Treating M.D.	Description
		Diabetes		
		Insulin Dependant		
		Non-Insulin Dependant		
		Eyes involvement/laser treatment		
		Nerve pain, if yes where?		
		High blood pressure		
		Stroke		
		Asthma		
		Arthritis		
		Any pain medication taken?		
		How long?		
		Daily or Occasional		
		High cholesterol		
		Cancer (where)		
		Heart attack		
		1 Angioplasty		
		2 Surgery		
		3 Most recent Angiogram		
		Congestive heart failure		
		Emphysema/COPD		
		Kidney stones		
		Urinary tract infection		
		Ulcers in stomach		
		Thyroid		
		Lupus / Autoimmune		
		Surgeries:		
		Tonsils/throat /sinus		
		Heart /Lung		
		Stomach/ Abdominal		
		Urinary tract /Prostate / Hysterectomy		
		Vascular/ bypass		
		Amputation		
		Others		

Allergies (medication or environmental or foods):

Family history: (Father, Mother, Sister, Brother, etc.) **Description**

		Diabetes	
		High blood pressure	
		Heart disease	
		Kidney failure	
		Kidney Stones	
		Blood in Urine	
		Cancer	
		Stroke	
		Others (including any genetic /familial disease)	

