NEPHROLOGY AND HYPERTENSION, P.C

FLINT	Grand Blanc	Owosso	East Lansing
G-1071 N. Ballenger Hwy.	9463 Holly Rd	802 W. King St.., Ste O	4530 S. Hagadorn Rd.
Suite 310	Suite 102	Mitchell Building	Suite B
Flint, MI 48504	Grand Blanc, MI 48439	Owosso, MI 48867	East Lansing, MI 48823
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NAME____BIRTHDATE___/___/___SEX_____________

ADDRESS__________________________________CITY____________________ ZIP_____________

PHONE_______________WORK#______________CELL________________SS#__________________

EMERGENCY CONTACT___________________ RELATIONSHIP ___________PHONE________________

EMERGENCY CONTACT____________________RELATIONSHIP__________PHONE_________________

PRIMARY CARE PHYSICIAN____PHONE________________

OTHER PHYS. SEEN____

PREFERRED PHARMACY ______________________________ LOCATION:_________________________

EMAIL ___________________________REASON FOR VISIT _________________________________

INSURANCE INFORMATION

INS. CO. ______________________________________CONTRACT #___________________________

POLICY HOLDER NAME ____________________________ BIRTHDATE ____________________________

POLICY HOLDER SOC.SEC.# _________________________ RELATIONSHIP TO PATIENT _________________

PAST MEDICAL HISTORY

DO YOU HAVE OR DO YOU TAKE MEDICATIONS FOR

□ ANEMIA
□ ASTHMA
□ ARTHRITIS
□ CANCER
□ CARDIAC ARRHYTHMIA
□ CONGESTIVE HEART FAILURE
□ COPD/EMPHYSEMA
□ CORONARY ARTERY DISEASE
□ DEMENTIA
□ DIABETES
□ HYPERLIPIDEMIA/HIGH CHOLESTEROL
□ HYPERTENSION/HIGH BLOOD PRESSURE
□ MYOCARDIAL INFARCTION/HEART ATTACK/HEART DISEASE
□ PARKINSONS DISEASE
□ PERIPHERAL ARTERIAL DISEASE/CIRCULATION
□ STROKE/MINI STROKE
□ THYROID PROBLEM
□ VALVULAR HEART DISEASE
□ OTHER (PLEASE LIST ON NEXT LINE)

OTHER MEDICAL PROBLEMS____

____

DRUG ALLERGIES____

SURGICAL HISTORY

LIST OF SURGERIES: ____

____

SOCIAL HISTORY

DO YOU SMOKE YES______ NO______ PACKS/DAILY_______________ HOW LONG_______________

DID YOU SMOKE IN THE PAST YES______ NO______ WHEN DID YOU QUIT_______________________

ALCOHOL TYPE/AMOUNT______________________NARCOTICS TYPE/AMOUT______________________

FAMILY HISTORY

	AGE	STATE OF HEALTH	CAUSE OF DEATH	AGE AT DEATH
FATHER				
MOTHER				
BROTHER(S)				
SISTER(S)				
SPOUSE				
CHILDREN				

SIGNATURE_______________________________ DATE_______________________________

REVIEWED BY PHYSICIAN_______________________________ DATE_______________________________

Updated 03/16