KIDNEY CARE CENTER
Your Partners In Health

Patient Health History

Name: **Date:**

Which of the following illnesses have you or any of your blood relatives had?

	I HAVE HAD	MY BLOOD RELATIVE HAVE HAD
Chicken Pox		
Measles		
Mumps		
Rubella (German Measles)		
Rheumatic Fever		
Tuberculosis		
Thyroid Disease		
Asthma		
Diabetes		
Epilepsy/Convulsions		
Rheumatism/Arthritis		
Heart Disease		
Lung Disease		
Hepatitis/Jaundice		
Kidney Infection/Stone		
Bladder Infection/Stone		
Sexually Transmitted Disease		
Tumor/Cancer		
Anemia		
Stroke		
Alcoholism		
Pneumonia		
Gall Bladder Disease		
Hypertension/ High Blood Pressure		
HIV/ AIDS		
Skin Disease		
Hay Fever		
Depression		
Sickle Cell Anemia		

PLEASE LIST ALL ALLERGIES:

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