TEREDESAI, McCANN & ASSOCIATES, P.C.
HYPERTENSION & KIDNEY SPECIALISTS

FAMILY HISTORY:

Indicate if any blood relative has had:

	Circle:	Who:
Diabetes	YES / NO	___________________________
Kidney Disease	YES / NO	___________________________
Hypertension	YES / NO	___________________________
Cancer	YES / NO	___________________________
Heart/Vascular Disease	YES / NO	___________________________
Stroke	YES / NO	___________________________
Kidney Stones	YES / NO	___________________________
Other	YES / NO	___________________________

SOCIAL HISTORY:

	number of:		number of:		
Coffee	______ Cups/ Day	or	______ Pots/Day	or	______ none
Tea	______ Cups/ Day	or	______ Pots/Day	or	______ none
Soft Drinks	______ Glasses/Day	or	______ Six Pack/Day	or	______ none
Alcoholic Beverages	______ Drinks/Day	or	______ Drinks/Week	or	______ none
Recreational Drugs	______ Uses/ Day	or	______ Uses/ Week	or	______none

(Type of Drugs used____)

Cigarettes:___Former Smoker: ______Per Day or ______ Packs/Day Quit date: __________
___Current Smoker: ______ Per Day or ______ Packs/Day
___Never Smoked

DIET RESTRICTIONS: (Please list any current diet restrictions, ie. Low salt, low calorie)

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