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

MEDICAL PROBLEMS:

Please mark if a doctor has ever told you that you had any of the following. Dates optional.

_____Sugar diabetes	_____High blood pressure	_____Bladder problem
_____Kidney infections	_____Heart disease	_____Cancer
_____Kidney stones	_____Prostate problems	type of cancer_____
_____Blood transfusions	_____Liver disease/jaundice	_____Stroke
	_____High Cholesterol	_____Other major illness

SURGERIES: (Please list all surgeries and approximate dates)

Operation	Year
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

MEDICATIONS: (Please list all over-the-counter and prescribed medications, dosages and frequencies.)

Medication Name *Example: aspirin*	Dose/Strength *325mg*	Amount/Frequency *1 every morning*
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

ALLERGIES: (Please list allergies to any medication, foods, x-ray, dyes etc. and give type of reaction.)

Allergy	Date Occurred	Reaction
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____