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)

_____
_____
_____
_____