GAYTRI GANDOTRA, MD
Nephrology

HISTORY & PHYSICAL

Name:		**DOB, Age**	
Email:		**Phone:**	
Referred by:		**Occupation:**	

HOSPITAL ADMISSIONS OR SURGERIES

Dates	Reason

Current Medications	Social History	
	Smoker?	If yes, how long?
	Former smoker?	If yes, how long?
	Coffee?	
	Drugs?	
	Alcohol?	If yes, how often?
Drug Allergies:		

MEDICAL HISTORY (CHECK ALL THAT APPLY)

Category	
High Blood Pressure	
Diabetes	
Heart Disease	
Overactive Bladder	___ Overnight > twice ___ > 8 times in 24 hours ___ Urgency to Urinate ___ Leakage ___ Decrease in flow ___ Painful
Blood in Urine	
Kidney Stones	
Urine Infections	
Weight Loss	
Anemia	
Cancer	
Thyroid Disease	
Other	

FAMILY HISTORY (CHECK ALL THAT APPLY)

	Father	Mother	Father's Parents	Mother's Parents	Siblings	Children
Heart Disease	❑	❑	❑	❑	❑	❑
High Blood Pressure	❑	❑	❑	❑	❑	❑
Stroke	❑	❑	❑	❑	❑	❑
Cancer	❑	❑	❑	❑	❑	❑
Glaucoma	❑	❑	❑	❑	❑	❑
Diabetes	❑	❑	❑	❑	❑	❑
Epilepsy/Convulsions	❑	❑	❑	❑	❑	❑
Bleeding Disorder	❑	❑	❑	❑	❑	❑
Kidney Disease	❑	❑	❑	❑	❑	❑
Thyroid Disease	❑	❑	❑	❑	❑	❑
Mental Illness	❑	❑	❑	❑	❑	❑
Osteoporosis	❑	❑	❑	❑	❑	❑

DATE OF LAST COLONOSCOPY:

FEMALES ONLY: **DATE OF LAST PAP SMEAR:**

DATE OF LAST MAMMOGRAM