Channahon Home Dialysis
Medical History Form

Personal Information

Name: ____ Date of Birth: __________________

Signature: _________________________ Date: _________ Phone Number: ____________________

Medical History

Surgeries/Hospitalizations:

____________________ Date: _________ _________________ Date: __________

____________________ Date: _________ _________________ Date: __________

____________________ Date: _________ _________________ Date: __________

History of (Circle all that apply):

Cataracts Glaucoma Cancer Diabetes Hepatitis STD Stroke Seizures Heart Attack Headaches
Paralysis Weakness Visual Problems Sleep Problems Hypertension Hypotension Asthma COPD

Allergies

___________________________________ Reaction ___________________________________

___________________________________ Reaction ___________________________________

___________________________________ Reaction ___________________________________

Medication Information

Do you take all medications as prescribed? (Please Circle) Yes No

Please list or provide a list of all current medications:

_______________________ Dose: ____________ ____________________ Dose: ___________

_______________________ Dose: ____________ ____________________ Dose: ___________

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