NDUKA-OBI OSSAI, MD, MRCPI
BOARD CERTIFIED IN NEPHROLOGY AND INTERNAL MEDICINE

KIDNEY DISEASE AND HYPERTENSION CENTER
OF NEW MEXICO, LLC

425 S. TELSHOR BLVD #C201B
LAS CRUCES, NM 88001-8235
PH: 575.288.2131 FX: 575.288.2101

Today's Date: / /

PLEASE PRINT

PATIENT INFORMATION

Last Name:	First:	Middle Initial:	Date of Birth: / /
Address:			Social Security Number: - -
City:	State:	Zip: -	Gender:
Home Phone:	preferred yes no		preferred language
Mobile Phone:	preferred yes no		Ethnicity – Hispanic/Latino yes no
Other Phone:		Work Phone:	preferred yes no
Race American Indian or Alaska Native Asian Black or African American Native Hawaiian or Pacific Islander White			Contact email
Referring Provider			
Primary Care Provider			

EMPLOYMENT INFORMATION

Occupation

EMERGENCY CONTACT

Name	Phone
Relationship	

NM Optimum Medical Group, LLC

Last Name	First	Date of Birth / /	Today's Date: / /

MARITAL

Marital Status:

Married Widowed

Single Separated

Divorced Domestic Partner

Spouse Name:		Date of Birth / /
Social Security Number: - -		Occupation:
Employer Name:		Work Phone:
Street Address:		
City:	State:	Zip: -

I certify that all the information contained in this medical health history is true to the best of my knowledge. I release Kidney Disease and Hypertension Center of New Mexico, LLC., from any and all responsibilities for actions stemming from incorrect information or information not given.

SIGNATURE: _____ **DATE:** _____

KIDNEY DISEASE AND HYPERTENSION CENTER OF NEW MEXICO, LLC

MEDICATION LIST

PATIENT NAME: _____ **DOB:** _____

Name of Medication	Dosage	How Often Taken	Date Medication Started

ALLERGIES:

FOOD OR MEDICINES	REACTION

PREFERRED PHARMACY INFORMATION

NAME OF PHARMACY: _____

ADDRESS: _____

PHONE NUMBER: _____

FAMILY HISTORY:

ILLNESS	YES	NO	RELATIONSHIP
HIGH BLOOD PRESSURE			
DIABETES			
KIDNEY DISEASE			
HEART DISEASE			
TUBERCULOSIS			
CANCER			
OTHER			
STROKE			

MOTHER: LIVING? _____ AGE (OR AGE AT DEATH) _____ ILLNESSES? _____

FATHER: LIVING? _____ AGE (OR AGE AT DEATH) _____ ILLNESSES? _____

SISTERS: NUMBER: _____ AGE(s) _____ ILLNESSES? _____

BROTHERS: NUMBER: _____ AGE(s) _____ ILLNESSES? _____

CHILDREN: NUMBER: _____ AGE(s) _____ ILLNESSES? _____

ARE YOU ON A SPECIAL DIET? [ ] YES [ ] NO

If so, what kind of diet are you on? _____

DO YOU NOW OR HAVE YOU EVER SMOKED? [ ] YES [ ] NO

If yes, how many packs per day? _____ How long? _____ When did you stop? _____

DO YOU NOW OR HAVE YOU EVER DRUNK ALCOHOL? [ ] YES [ ] NO

Beer? _____ Hard Liquor? _____ If so, how much? _____ When did you stop? __

DO YOU USE DRUGS OTHER THAN THOSE PRESCRIBED BY YOUR DOCTOR?

[ ] YES [ ] NO If yes, what drugs? _____

PATIENT HISTORY

DATE: _____

PATIENT NAME: _____

MEDICAL ILLNESSES:

ILLNESS	PRESENT	DURATION
HIGH BLOOD PRESSURE		
KIDNEY DISEASE		
DIABETES MELLITUS		
KIDNEY STONES		
HEART DISEASE		
ATHEROSCLEROSIS		
HIGH CHOLESTEROL		
HARDENING OF THE ARTERIES		
TOXEMIA		
LUNG DISEASE		
CANCER		
LUPUS		
ARTHRITIS		
GI ILLNESS (STOMACH)		
ULCERS		
ANEMIA		
STROKE		
ALLERGIES		
PROSTATE DISEASE NEUROLOGICAL DISEASE		
SEIZURES		
PSYCHIATRIC DISEASE		
SLEEP DISORDERS		
EYE DISEASE		

SURGICAL HISTORY:

DATE	SURGERY	SURGEON

SYMPTOMS:

SYMPTOM	PRESENT	DURATION
BLOOD IN URINE		
PUS IN URINE		
FOAMY URINE		
PAINFUL URINATION		
FREQUENT URINATION		
URINATION AT NIGHT		
INCONTINENCE		
URGENT URINATION		
INCOMPLETE BLADDER EMPTYING		
SWELLING		
FLANK PAIN		
STONE IN URINE		
RASH		
FEVER		
SWALLOWING PROBLEMS		
HEARING PROBLEMS		

TRANSFUSIONS IN PAST?: _____

WHEN: _____