Patient's Information Form: **Date:**

Contact Information:

Name:		State:	
Age:		Postal Code:	
Gender:		Country	
eMail Address:		Home Phone:	
Address:		Mobile/Cel Phone:	
City:			

Lab Investigations:

Date of Test:	(DD-MM-YYYY)		
HB:		Serum Uric Acid:	
TLC:		Blood Urea:	
DLC:		Serum Creatinine:	
Blood Sugar:			

Electrolytes

Sodium:		Potassium:	
Calcium:		Phosphorus:	

Additional Reports:

* Please attach additional sheet to provide information about Urine Routine Test and Ultra Sound Abdomen with Kidneys

Additional Questions:

1. What is your current blood pressure? Systolic: Diastolic:
2. Are you diabetic?
3. Do you have family history of kidney disease?
4. Are you allergic to any food, medicine or weather?
5. What is your liquid intake/output? In ml Input: Output:
6. How is your appetite?
7. Is there any constipation or loose stool?
8. Is there any nausea or vomiting?
9. Do you have breathlessness?
10. Do you feel weak?
11. Are you experiencing itching?
12. Is there swelling? (feet, legs, face etc.)
13. Are you on dialysis?
14. How long have you been on dialysis?
15. If it is haemodialysis – what is the frequency? /week
16. What medicine(s) are you currently taking?
17. Any additional info?
18. How did you hear about us?

*once filled, please send this form as an attachment to info@kundankidneycare.com