



Medical History • *Historia Medica*

Date • *Fecha de hoy:* _____

Patient Name • *Nombre del paciente:* _____

DOB • *Fecha de nacimiento:* _____

Primary Care Physician • *Doctor Particular:* _____

Allergies to Medications • *Alergias a medicamentos:* _____

Other Allergies • *Otras Alergias (i.e. Latex, Dye, Food):* _____

Health Problems • *Problemas de Salud*— Check all that apply // *Marque todas las que se aplican*

Yes <i>Si</i>	No <i>No</i>		Yes <i>Si</i>	No <i>No</i>	
<input type="checkbox"/>	<input type="checkbox"/>	Stroke • <i>Embolio</i>	<input type="checkbox"/>	<input type="checkbox"/>	Allergies • <i>Alergias</i>
<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease • <i>Enfermedad de Corazón</i>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease • <i>Enfermedad de riñones</i>
<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack • <i>Ataque de Corazon</i>	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice/Hepatitis • <i>Ictericia</i>
<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever • <i>Fiebre reumatica</i>	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure • <i>Alta presion</i>
<input type="checkbox"/>	<input type="checkbox"/>	Emphysema • <i>Pulmonia</i>	<input type="checkbox"/>	<input type="checkbox"/>	Cancer
<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Back Problems • <i>Problemas de espalda</i>
<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia • <i>Neumonía</i>	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis • <i>Artitis</i>
<input type="checkbox"/>	<input type="checkbox"/>	Bleeding/Clotting Problems • <i>Hemorragia o problemas de coagulación</i>	<input type="checkbox"/>	<input type="checkbox"/>	Stomach/Ulcer Problem <i>Problema del estomago o ulceras</i>
<input type="checkbox"/>	<input type="checkbox"/>	Speech/Hearing Problems • <i>Problemas con el habla o escuchando</i>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes • <i>Diabetis</i>
<input type="checkbox"/>	<input type="checkbox"/>	Blood Transfusions • <i>Transfusiones de sangre</i>	<input type="checkbox"/>	<input type="checkbox"/>	Other • <i>Otro</i>

Date • *Fechas* _____

Previous Surgeries • *Cirugías de el Pasado* — Check all that apply • *Marque todas las que se aplican*

	Date • <i>Fecha</i>		Date • <i>Fecha</i>
<input type="checkbox"/> Ear/Nose/Throat <i>Oido/Naris/Garganta</i>	_____	<input type="checkbox"/> Hysterectomy • <i>Matis</i>	_____
<input type="checkbox"/> Appendectomy • <i>Apedice</i>	_____	<input type="checkbox"/> Hernia	_____
<input type="checkbox"/> Eye • <i>Ojo</i>	_____	<input type="checkbox"/> Hemorrhoid • <i>Hemorroides</i>	_____
<input type="checkbox"/> Breast • <i>Pechos o Seno</i>	_____	<input type="checkbox"/> Back/Neck • <i>Espalda o Cuello</i>	_____
<input type="checkbox"/> Gallbladder • <i>Vesicula Biliar</i>	_____	<input type="checkbox"/> Joints (Hip/Knee)	_____
<input type="checkbox"/> Heart/Vascular <i>Corazón/Vascularision</i>	_____		
<input type="checkbox"/> Other • <i>Otro</i>	_____		

Other Hospitalizations • *Otras estancias en el hospital* _____

Family History • *Historia Familiar*

<input type="checkbox"/> Heart Disease • <i>Enfermedad de Corazón</i>	<input type="checkbox"/> Cancer
<input type="checkbox"/> Diabetes • <i>Diabetis</i>	<input type="checkbox"/> Stroke • <i>Embolio</i>
<input type="checkbox"/> High Blood Pressure • <i>Alta presion</i>	<input type="checkbox"/> Other • <i>Otro</i> _____



Social History • Historia Social

Do you or have you ever smoked? • ¿Fuma or ha fumado en el pasado? _____

How much a day? • ¿Cuanto al día? _____

Do you consume alcohol? • ¿Toma bebidas alcoholicas? _____

How much a day? • ¿Cuanto al día? _____

Do you use illegal drugs? • ¿Usa drogas ilegales? _____

How much a day? • ¿Cuanto al día? _____

**Current Medications/Prescription or Over the Counter •
Nombre de medicamentos que toma usted, con receta o sin receta**

Name of Medication

Nobre de Medicina

Dosage

Miligramos o Cucharadas

Pharmacy • Farmacia

Name • Nombre: _____

Address • Dirección: _____

Phone Number • Numero de teléfono: _____



Patient Name: _____ DOB: _____ Date: _____

Are you currently experiencing any of the following?

Constitutional Symptoms

- Good general health lately No Yes
- Recent weight gain No Yes
- Recent weight loss No Yes
- Fever No Yes
- Fatigue No Yes

Eyes

- Eye disease or injury No Yes
- Wear glasses/contact lens No Yes
- Blurred or double vision No Yes
- Glaucoma No Yes

Ears/Nose/Throat/Mouth

- Hearing loss or ringing No Yes
- Earaches or drainage No Yes
- Chronic sinuses problems or rhinitis ... No Yes
- Nose bleeds No Yes
- Mouth sores No Yes
- Bleeding gums No Yes
- Bad breath or bad taste No Yes
- Sore throat No Yes
- Voice change No Yes
- Swollen glands in neck No Yes

Cardiovascular

- Heart trouble No Yes
- Chest pain or angina pectoris No Yes
- Palpitation No Yes
- Shortness of breath with walking No Yes
- Shortness of breath while laying flat ... No Yes
- Swelling of feet, ankles or hands No Yes

Respiratory

- Chronic or frequent cough No Yes
- Spitting up blood No Yes
- Shortness of breath No Yes
- Difficulty breathing No Yes
- Wheezing No Yes

Psychiatric

- Memory loss or confusion No Yes
- Nervousness No Yes
- Depression No Yes
- Insomnia No Yes

Gastrointestinal

- Loss of appetite No Yes
- Change in bowel movements No Yes
- Nausea or vomiting No Yes
- Frequent diarrhea No Yes
- Painful bowel movements No Yes
- Constipation No Yes
- Rectal bleeding or blood in stool No Yes
- Abdominal pain or heartburn No Yes
- Peptic ulcer (stomach or duodenal) No Yes

Genitourinary

- Frequent urination No Yes
- Burning or painful urination No Yes
- Blood in urine No Yes
- Change in force of strain
when urinating No Yes
- Incontinence or dribbling No Yes
- Kidney stones No Yes
- Sexual difficulty No Yes
- Male - testicle pain No Yes
- Female - pain with periods No Yes
- Female - irregular periods No Yes
- Female - vaginal discharge No Yes

Musculoskeletal

- Joint pain No Yes
- Joint stiffness or swelling No Yes
- Weakness of muscles/joints No Yes
- Muscle pain or cramps No Yes
- Back pain No Yes
- Cold extremities No Yes
- Difficulty in walking No Yes



Integumentary (skin, breast)

- Rash or itching No Yes
- Change in skin color No Yes
- Change in hair or nails No Yes
- Varicose veins No Yes
- Breast pain No Yes
- Breast lump No Yes
- Breast discharge No Yes

Neurological

- Frequent or recurring headaches No Yes
- Light headed or dizzy No Yes
- Convulsions or seizures No Yes
- Numbness or tingling sensations No Yes
- Tremors No Yes
- Paralysis No Yes
- Stroke No Yes
- Head injury No Yes

Endocrine

- Glandular or hormone problem No Yes
- Thyroid disease No Yes
- Diabetes No Yes
- Excessive thirst or urination No Yes
- Heat or cold intolerance No Yes
- Skin becoming dryer No Yes
- Change in hat or glove size No Yes

Hematologic/Lymphatic

- Slow to heal after cuts No Yes
- Bleeding or bruising tendency No Yes
- Anemia No Yes
- Phlebitis No Yes
- Enlarged glands No Yes

Allergic/Immunologic

Skin reaction or other adverse reaction to:

- Penicillin or other antibiotics No Yes
- Morphine, Demerol or other
narcotics No Yes
- Novocaine or other anesthetics No Yes
- Aspirin or other pain remedies No Yes
- Tetanus antitoxin or other serums No Yes
- Iodine, methiolate or other
antiseptic No Yes