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

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

	Date • *Fecha*		Date • *Fecha*
☐ Ear/Nose/Throat *Oido/Naris/Garganta*	_____	☐ Hysterectomy • *Matis*	_____
☐ Appendectomy • *Apedice*	_____	☐ Hernia	_____
☐ Eye • *Ojo*	_____	☐ Hemorrhoid • *Hemorroides*	_____
☐ Breast • *Pechos o Seno*	_____	☐ Back/Neck • *Espalda o Cuello*	_____
☐ Gallbladder • *Vesicula Biliar*	_____	☐ Joints *(Hip/Knee)*	_____
☐ Heart/Vascular *Corazón/Vascularision*	_____		

☐ Other • *Otro* _____

Other Hospitilizations • *Otras estancias en el hospital* _____

Family History • ***Historia Familiar***

☐ Heart Disease • *Enfermedad de Corazón*	☐ Cancer
☐ Diabetes • *Diabetis*	☐ Stroke • *Embolio*
☐ High Blood Pressure • *Alta presion*	☐ Other • *Otro* _____

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Social History • *Historia Social*

Do you or have you ever smoked? •¿Fuma or ha fumado en el pasado? _____
How much a day? • *¿Cuanto al dia?* _____

Do you consume alcohol? • *¿Toma bebidas alcoholicas?* _____
How much a day? • *¿Cuanto al dia?* _____

Do you use illegal drugs? • *¿Usa drogas ilegales?* _____
How much a day? ☒ *¿Cuanto al dia?* _____

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:* _____

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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

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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