MEDICAL HISTORY (Page 1 of 3) *HISTORIA MEDICA*

Patient Name: *Nombre del paciente* _____

Date of Birth: *Fecha de nacimiento* _____

Primary Care Physician: *Doctor particular* _____

Today's Date: *Fecha de hoy* _____

Allergies to Medication: *Alergias a medicamentos* _____

BRIEFLY DESCRIBE YOUR CURRENT SYMPTOMS:

_____

_____

_____

_____

Date symptoms began (approximate):_____ **Diagnosis given?**_____

Previous treatment for this problem (include physical therapy, surgery and injections; medications to be listed later):

_____

_____

_____

Please list the names of any other practitioners you have seen for this problem: _____

_____

SYSTEMS REVIEW -- Do you now or have you had any problems related to the following systems? Circle Yes or No. Please explain any Yes answers in the space provided.

Constitutional Symptoms		
Fatigue	Y	N
Fever/Chills	Y	N
Headache	Y	N
Night Sweats	Y	N
Poor Sleep	Y	N
Weight Loss	Y	N
Other:		

Eyes		
Blurred/Double Vision	Y	N
Dry Eyes	Y	N
Redness	Y	N
Pain	Y	N
Other:		

Allergic/Immunologic		
Drug Allergies	Y	N
Hay Fever	Y	N
Other:		

Neurological		
Dizzy Spells	Y	N
Numbness/Tingling	Y	N
Muscle Weakness	Y	N
Tremors	Y	N
Other:		

Gastrointestinal		
Abdominal Pain	Y	N
Blood in Stools	Y	N
Diarrhea	Y	N
Difficulty Swallowing	Y	N
Indigestion/Heartburn	Y	N
Nausea/Vomiting	Y	N
Other:		

Musculoskeletal		
Back Pain	Y	N
Joint Pain	Y	N
Joint Swelling	Y	N
Morning Stiffness	Y	N
< 30 min / 30-60min / > 1hour		
Neck Pain	Y	N
Other:		

Integumentary		
Boils	Y	N
Color Change in Fingers/Toes	Y	N
Hair Loss	Y	N
Persistent Itch	Y	N
Sun Photosensitivity	Y	N
Skin Rash	Y	N
Other:		

Ear/Nose/Throat/Mouth		
Dry Mouth	Y	N
Ear Infection	Y	N
Jaw Pain	Y	N
Hearing Loss	Y	N
Hoarseness	Y	N
Oral Ulcers	Y	N
Sinus Problems	Y	N
Sore Throat	Y	N
Other:		

Respiratory		
Coughing Blood	Y	N
Frequent Cough	Y	N
Shortness of Breath	Y	N
Snoring	Y	N
Wheezing	Y	N
Other:		

Genitourinary		
Blood in Urine	Y	N
Painful Urination	Y	N
Urethral Discharge	Y	N
Urinary Frequency	Y	N
Vaginal Ulcers	Y	N
Other:		

Endocrine		
Excessive Thirst	Y	N
Too hot/cold	Y	N
Weight Gain	Y	N
Other:		

Cardiovascular		
Chest Pain	Y	N
High Blood Pressure	Y	N
Palpitations	Y	N
Swollen Legs/Feet	Y	N
Other:		

Hematologic/Lymphatic		
Anema	Y	N
Blood Clotting Problem	Y	N
Recurrent Infections	Y	N
Swollen Glands	Y	N
Other:		

Psychological		
Are you generally satisfied with your life?	Y	N
Do you feel severly depressed?	Y	N
Have you considered suicide?	Y	N
Other:		

MEDICAL HISTORY (Page 2 of 3) *HISTORIA MEDICA*

HEALTH PROBLEMS – *Problemas de salud*

YES *Si*	NO *No*		YES *Si*	NO *No*	
[ ]	[ ]	Rheumatoid Arthritis *Artritis Reumatoide*	[ ]	[ ]	Heart Disease *Enfermedad de Corazón*
[ ]	[ ]	Lupus *El lupus*	[ ]	[ ]	High Blood Pressure *Alta Presion*
[ ]	[ ]	Sjogren's	[ ]	[ ]	High Cholesterol *Colesterol Alto*
[ ]	[ ]	Arthritis *Artritis*	[ ]	[ ]	Jaundice/Hepatitis *Ictericia*
[ ]	[ ]	Allergies *Alergias*	[ ]	[ ]	Kidney Disease *Enfermedad de Rinones*
[ ]	[ ]	Back Problems *Problemas de Espalda*	[ ]	[ ]	Neuropathy *Neuropatia*
[ ]	[ ]	Bleeding/Clotting Problems *Hemorragia oproblemas de coagulacion*	[ ]	[ ]	Pneumonia *Neumonia*
[ ]	[ ]	Blood Transfusions *Transfusiones de Sangre*	[ ]	[ ]	Speech/Hearing Problems *Problemas con el habla o escuchando*
[ ]	[ ]	Cancer *Cáncer*	[ ]	[ ]	Stomach/Ulcer Problems *Problema del Estomago o Ulceras*
[ ]	[ ]	Diabetes *Diabetes*	[ ]	[ ]	Stroke *Embolio*
[ ]	[ ]	Emphysema *Pulmonia*	[ ]	[ ]	Tuberculosis *La Tuberculosis*
[ ]	[ ]	Heart Attack *Ataque de Corazón*	[ ]	[ ]	Other: Otro _____

PREVIOUS SURGERIES – *Cirugias en el pasado*

Date *Fecha*		Date *Fecha*	
__ /__ /__	Ear/Nose/Throat *Oido/Nariz/Garganta*	__ /__ /__	Hysterectomy *Metris*
__ /__ /__	Eye *Ojo*	__ /__ /__	Hernia *Hernia*
__ /__ /__	Breast *Pechos o Seno*	__ /__ /__	Hemorrhoid *Hemorroides*
__ /__ /__	Gallbladder *Vesicula Biliar*	__ /__ /__	Back/Neck *Espalda o Cuello*
__ /__ /__	Heart/Vascular *Corazon/Vascularision*	__ /__ /__	Joints Hip/Knee *Rodilla/Cadera*
Other Surgeries: *Otro*		Other Hospital Stays: *Otras estancias en el hospital*	

MEDICAL HISTORY (Page 3 of 3) *HISTORIA MEDICA*

FAMILY HISTORY – *Historia familiar*

[ ] Heart Disease
Enfermedad de Corazon

[ ] Diabetes
Diabetes

[ ] High Blood Pressure
Alta Presion

[ ] Cancer
Cáncer

[ ] Other
Otra

[ ] Stroke
Embolia

[ ] Rheumatoid Arthritis
Artritis reumatoide

[ ] Lupus
Lupus

[ ] Scleroderma
Esclerodermia

SOCIAL HISTORY – *Historia Social*

Do you or have you ever smoked? *¿Usted o alguna vez ha fumado?* _____ How much a day? *¿Cuánto al día?* _____

Do you consume alcohol? *¿Toma bebidas alcohólicas?* _____ How much a day? *¿Cuánto al día?* _____

What is your marital status? *¿Cuál es su estado civil?* _____ # of children? *¿número de niños?* _____

CURRENT MEDICATIONS/PRESCRIPTIONS OR OVER THE COUNTER

Nombre de medicamentos que toma con receta o sin receta

MEDICATION & DOSAGE - *Medicina & miligramos*	**MEDICATION & DOSAGE -** *Medicina & miligramos*
1.	*11.*
2.	*12.*
3.	*13.*
4.	*14.*
5.	*15.*
6.	*16.*
7.	*17.*
8.	*18.*
9.	*19.*
10.	*20.*

PHARMACY - *Farmacia*

Name – *Nombre*

Address – *Dirección*

Phone number – *Numero de teléfono*