**ADULT MEDICAL HISTORY/HISTORIAL MEDICO**



TODAY’S DATE/*Fecha de hoy* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PATIENT’S NAME/*Nombre del paciente* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB/*Fecha de Nacimiento*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SS#/ *No. Seguro Social* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Previous Physician/*Nombre del médico anterior* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When was your last medical exam? *Fecha del último examen médico*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been hospitalized?/¿*Ha estado hospitalizado?* 🞎 Yes/Sí 🞎No

If yes, please explain, for what?/*Si responde que sí, explique, ¿por qué?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

**⌦** For which of the following conditions are you currently being treated, or have been treated for in the past? / ¿Para *cuál de las siguientes condiciones está recibiendo tratamientonte o ha sido tratado en el pasado? (Favor de seleccionar todas las que apliquen*)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Heart disease – Enfermedad *del corazón* |  | Cancer – *Cáncer* |  | Anemia - Anemia |
|  | Heart murmur– *Soplo* |  | Arthritis – Artritis |  | Blood problems – Problemas de la sangre |
|  | Angina - *Angina* |  | Diabetes – Diabetes |  | Sickle Cell Anemia – Anemia falciforme |
|  | Stroke – Derrame cerebral |  | Thyroid problems – Problemas de tiroides |  | Hepatitis A |
|  | High blood pressure - *Hipertensión* |  | Neurologic problems – Problemas neurológicos |  | Hepatitis B |
|  | High cholesterol – Colesterol alto |  | Convulsions – Convulsiones |  | STD or HIV – Enfermedades transmitidas sexualmente o VIH |
|  | Lung problems – Problema pulmonary |  | Headaches – Dolores de cabeza |  | Tonsillitis - Amigdalitis |
|  | Shortness of breath – Falta de aire |  | Migraines – Migrañas |  | Ear problems – Problemas con los oídos |
|  | Asthma – *Asma* |  | Depression – Depresión |  | Glaucoma |
|  | Cough – Tos |  | Anxiety – Ansiedad |  | Eye problems – Problemas con los ojos |
|  | Ulcers/Colitis – Ulceras/Colitis |  | Psychiatric care – Cuidado psiquiátrico |  | Allergies - Alergias |
|  | Heartburn/Reflux – Acidez/Agrura |  |  |  | Sinus problems – Problemas de sinusitis |

Please tell us about health problems not listed above. *Por favor describa cualquier problema de salud que no se haya mencionados anteriormente.*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any surgery you have had and when. *Por favor lista las cirugías que haya tenido y cuándo.*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you allergic to penicillin or other drugs? *Alérgico a la penicilina o otra droga?* 🞎 Yes/Sí \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_🞎 No

✓Check if you are allergic to/ *Marque si usted es alérgico a:*

🞎Latex/rubber gloves - L*átex / guantes de goma*

🞎Eggs - Huevos

🞎Shellfish – Mariscos/Crustáceos

🞎 Nuts - Nueces

🞎Other allergy – Otras alergias \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICATIONS/*MEDICAMENTOS***

|  |  |  |
| --- | --- | --- |
| **Name of medicine**  ***Nombre de la medicina*** | **Dose/ *dosis* -*tamaño de la pastilla*** | **How many pills or doses do you take at?:**  ***¿Cuántas pastillas o dósis se toma en*** |
|  |  | ***Desayuno Mediodía Cena Al dormir***  morning \_ noon dinner bedtime |
|  |  | morning noon dinner bedtime |
|  |  | morning noon dinner bedtime |
|  |  | morning noon dinner bedtime |
|  |  | morning noon dinner bedtime |
|  |  | morning noon dinner bedtime |
|  |  | morning noon dinner bedtime |
|  |  | morning noon dinner bedtime |
|  |  | morning noon dinner bedtime |
|  |  | morning noon dinner bedtime |

Do you smoke? *Fuma cigarillo o tabaco?* 🞎Yes/Sí 🞎No Have you in the past? *Ha fumado en el pasado?* 🞎Yes/Sí 🞎No

How many packs per day? ¿*Cuántos paquetes por día?* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you drink alcohol, beer or wine? ¿*Toma alcohol, cerveza o vino?* 🞎Yes/Sí 🞎No

If no, have you in the past? ¿*Ha bebido en el pasado?* 🞎 Yes/Sí 🞎No

How many drinks per week? ¿*Cuántas bebidas alcohólicas por semana?* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you drink coffee or tea? ¿*Toma café o té?* 🞎 Yes/Sí 🞎No

How many cups per day? *Cuantas tazas al dia*? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you exercise daily or weekly? ¿Hace ejercicio diaro o semanal? 🞎 Yes/Sí 🞎 No

Do you use the seatbelt when driving? ¿Usa el cinturón de seguridad cuando maneja? 🞎 Yes/Sí 🞎No

Do you wear a helmet when riding a bike? ¿Usa el casco cuando monta bicicleta? 🞎 Yes/Sí 🞎No

**FAMILY HISTORY/ *HISTORIAL FAMILIAR***

Has anyone in your family, including children and parents, suffered or died from any of these diseases? Explain.

*¿Algún miembro de su familia, incluyendo niños y padres, han tenido o muerto de alguna de las siguentes enfermedades? Explique.*

Anemia or blood problems/*Anemia o problemas sanguíneos*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cancer/Cáncer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Diabetes\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Glaucoma \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Heart Problems/*Problemas del Corazón* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

High blood pressure/*Hipertensión\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

HIV/ AIDS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mental health problems/Depression/*Problemas mentales/ Depresión\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

Stroke/Derrame *Cerebral \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

Other serious disease/*Otra enfermedad severa\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

FOR WOMEN/ PARA MUJERES – GYNECOLOGIC HISTORY/HISTORIAL GINECOLOGICO

How many times have you been pregnant? ¿*Cuántas veces ha estado embarazada?* \_\_\_\_\_

Date of your last PAP test? ¿Cuál es la f*echa de su último papanicolau?* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had an abnormal PAP? ¿*Ha tenido un papanicolau no normal?* 🞎Yes/Sí 🞎No

Have you been diagnosed with a sexually transmitted disease? ¿Le han diagnosticado con alg*una enfermedad de transmisión sexual?* 🞎 Yes/Sí 🞎No Diagnosis/*Diagnóstico*  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of your last mammogram? ¿Cuándo fue su *última mamografía?* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had a breast biopsy? ¿*Le han practicado biopsia en los senos*? 🞎Yes/Sí 🞎No

PLEASE DESCRIBE BELOW THE PRIMARY REASON YOU ARE HERE TO SEE US TODAY:

POR FAVOR DESCRIBA ABAJO LA RAZON PRINCIPAL POR LA CUAL USTED ESTA AQUÍ PARA VERNOS HOY:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**By signing below, I hereby certify that to the best of my knowledge all of the information I have furnished on this form is complete, true and accurate.**

***Al firmar abajo, yo certifico que, a lo mejor de mi conocimiento, toda la información que he dado en este formulario es completa, veraz y exacta.***

**Patient/Legal Guardian Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

***Firma del paciente o guardián Fecha***

ADULT MEDICAL HISTORY 1/27/13\_REVISED\_NM