

**PATIENT NAME/**

**NOMBRE DEL PACIENTE:** \_\_\_\_\_

**MEDICAL HISTORY – Circle all conditions that you have or have had in the past**  
**HISTORIA MEDICA – Rodee todas condiciones que usted tiene o ha tenido en el pasado**

|  |   |  |   |  |
|--|---|--|---|--|
| <b>Anemia/</b><br>Anemia   | <b>Gallbladder/</b><br>Visicula               | <b>Menopuase/</b><br>Menopausia                        | <b>Anxiety/</b><br>Ansiedad                               | <b>Glaucoma/Cataract</b><br>Glaucoma/Cataratas       |
| <b>Menstrual irregularities/</b><br>Irregularidades de mentraucion | <b>Arthritis/</b><br>Artritis                 | <b>Gout/</b><br>Gota                                   | <b>Osteoporosis/</b><br>Osteoporosis                      | <b>Arteries Disease/</b><br>Problemas de Arterias    |
| <b>Headaches/</b><br>Dolores de cabeza                             | <b>Pneumonia/</b><br>Pulmonia                 | <b>Asthama/</b><br>Asma                                | <b>Hearing Loss/</b><br>Pérdida Auditiva                  | <b>Prostate Disease/</b><br>Problemas de la Prostata |
| <b>Blood Clotting/</b><br>Coagulación de Sangre                    | <b>Heart Attack/</b><br>Infarto               | <b>Rheumatic fever/</b><br>Fiebre Reumática            | <b>Breast Disease/</b><br>Enfermedad de Seno              | <b>Heart Murmur/</b><br>Soplo en el corazón          |
| <b>Seasonal allergies/</b><br>Alergias Estacionales                | <b>Bronchitis/</b><br>bronquitis              | <b>Heart Palpitations/</b><br>Palpitaciones de corazón | <b>S.T.D/</b><br>Enfermedad de transmisión sexual         | <b>Cancer/</b><br>Cancer                             |
| <b>Heartburn/</b><br>Acidez  | <b>Sinusitis/</b><br>Sinisitis                | <b>Chronic Rashes/</b><br>Erupciones Crónicas          | <b>Hepatitis or Liver Disease/</b><br>Hepatitis           | <b>Stomach Disoder/</b><br>Desorden de Estómago      |
| <b>Depresión/</b><br>Depresion                                     | <b>Cholesterol/</b><br>Colesterol             | <b>Stroke/</b><br>Embolio                              | <b>Diabetes/</b><br>Diabetes                              | <b>Immunodeficiency Disease/</b>                     |
| <b>Thyroid Disease/</b><br>Enfermedad de tiroides                  | <b>Dizziness/Fainting</b><br>Mareo/desmayando | <b>Insomnia/</b><br>Insomnio                           | <b>Trauma/</b><br>Trauma                                  | <b>Emphysema or COPD/</b><br>Enfisema                |
| <b>Intestinal Disoder/</b><br>Disoder intestinal                   | <b>Ulcers/</b><br>Ulceras                     | <b>Frequent infections/</b><br>Infecciones frecuentes  | <b>Veins – problems or disease/</b><br>Problemas de Venas | <b>High Blood Pressure/</b><br>Alta Precion          |

**SURGERY & HOSPITALIZATION HISTORY**  
**CIRUGIA Y HISTORIA DE HOSPITALIZACIONES**

| <b>DATE/ FECHA</b> | <b>REASON/ RAZON</b> |
|--------------------|----------------------|
|                    |                      |
|                    |                      |
|                    |                      |

**LIFE STYLE**  
**ESTILO DE VIDA**

|                            | <b>TYPE/ CLASE</b> | <b>HOW MUCH/ CUANTO</b> | <b>HOW OFTEN/ CONQUE FRECUENCIA</b> | <b>WHEN STARTED/ CUANDO COMENZADO</b> | <b>WHEN STOPPED/ CUANDO PARO</b> |
|----------------------------|--------------------|-------------------------|-------------------------------------|---------------------------------------|----------------------------------|
| <b>ALCOHOL/ ALCOHOL</b>    |                    |                         |                                     |                                       |                                  |
| <b>DRUGS/ DROGAS</b>       |                    |                         |                                     |                                       |                                  |
| <b>EXERCISE/ EJERCICIO</b> |                    |                         |                                     |                                       |                                  |
| <b>NICOTINE/ NICOTINA</b>  |                    |                         |                                     |                                       |                                  |

**PATIENT NAME/**  
**NOMBRE DEL PACIENTE :** \_\_\_\_\_

**MEDICINE/VITAMINS/HERBALS TAKEN**  
**MEDICINAS/VITAMINAS QUE TOMA**

| NAME/NOMBRE | MILLIGRAMS/MILIGRAMO | TIMES TAKEN PER DAY/Cuantas al dia |
|-------------|----------------------|------------------------------------|
|             |                      |                                    |
|             |                      |                                    |
|             |                      |                                    |
|             |                      |                                    |

**MEDICINE ALLERGIES- LIST MEDICINES WITH ALLERGIC REACTIONS CAUSED**  
**ALERGIAS A MEDICAMENTO- LISTE LOS MEDICAMENTOS QUE CAUSEN ALERGIAS**

| MEDICINE/MEDICINA | REACTIONS/ REACCIONES |
|-------------------|-----------------------|
|                   |                       |
|                   |                       |
|                   |                       |

**FAMILY HISTORY – CHECK BOXES THAT APPLY**  
**HISTORIA FAMILIAR – MARQUE LA CAJA QUE APLICA**

|   | MOTHER/<br>MADRE | FATHER/<br>PADRE | MOTHERS<br>PARENTS/<br>ABUELOS<br>MATERNOS | FATHERS<br>PARENTS/<br>ABUELOS<br>PATERNOS | SIBLINGS/<br>HERMANOS | YOUR<br>CHILDREN/<br>HIJOS |
|---|------------------|------------------|--|--|-----------------------|----------------------------|
| <b>CANCER/CANCER</b>                                |                  |                  |  |  |                       |                            |
| <b>DEMENTIA/DEMENCIA</b>                            |                  |                  |  |  |                       |                            |
| <b>DIABETES/DIABETES</b>                            |                  |                  |  |  |                       |                            |
| <b>EPILEPSY/CONVULSIONES</b>                        |                  |                  |  |  |                       |                            |
| <b>GLAUCOMA/GLAUCOMA</b>                            |                  |                  |  |  |                       |                            |
| <b>HEART DISEASE/<br/>PROBLEMAS DEL<br/>CORAZON</b> |                  |                  |  |  |                       |                            |
| <b>HIGH BLOOD PRESSURE/<br/>ALTA PRECION</b>        |                  |                  |  |  |                       |                            |
| <b>MENTAL ILLNESS/<br/>PROBLEMAS MENTALES</b>       |                  |                  |  |  |                       |                            |
| <b>STROKE/EMBOLIO</b>                               |                  |                  |  |  |                       |                            |
| <b>THYROID DISEASE/<br/>ENFERMEDAD DE TIROIDES</b>  |                  |                  |  |  |                       |                            |