ADULT HEALTH HISTORY:

Name/Nombre:	Age/Edad:	D.O.B./Cuando Nacio:	Date/Fecha:

HISTORY OF PAST ILLNESS Have you had?/ENFERMEDADES PASADAS: (Ha tenido)

Measles/Sarampion.....	No	Yes/Si	Rheumatic fever/Fiebre Reumatica.....	No	Yes/Si
Mumps/Paperas.....	No	Yes/Si	Heart Disease/Enfermedad del Corazon.....	No	Yes/Si
Chickenpox/Viruela.....	No	Yes/Si	Tuberculosis.....	No	Yes/Si
Diabetes.....	No	Yes/Si	Venereal Disease/Enfermedad Veneria.....	No	Yes/Si
Strokes/Embolio.....	No	Yes/Si	Serious Disease/Enfermedad Graves.....	No	Yes/Si

Ever hospitalized/Ha sido hospitalisado..... No Yes/Si Explain/Explicacion_____
Ever had surgery/Ha tenido operaciones..... No Yes/Si Explain/Explicacion_____
Had broken bones/Ha tenido fracturas..... No Yes/Si Explain/Explicacion_____
Head concusiions or injuries/Glopes o Heridas de cabeza..... No Yes/Si Explain/Explicacion_____
Date of Last Tetanus Shot/La Fecha de su ultima immunizacion de Tetno_____
Date of Last PAP Smear/La Fecha de papanicolou exam de cancer_____
Date of Last Mammogram/Mammographia_____

FAMILY HISTORY/HISTORIA FAMILIAR:

Has anyone in your family ever had?/Ha habido en su familia?

Cancer..... No Yes/Si Who/Quien?_____
Diabetes..... No Yes/Si Who/Quien?_____
Tuberculosis..... No Yes/Si Who/Quien?_____
Heart trouble/Enfermedad del Corazon..... No Yes/Si Who/Quien?_____
High blood pressure/Presion alta..... No Yes/Si Who/Quien?_____
Stroke/Embolio..... No Yes/Si Who/Quien?_____
Convulsions/Epilepcia..... No Yes/Si Who/Quien?_____
Suicide/Suicidio..... No Yes/Si Who/Quien?_____

SOCIAL HISTORY/HISTORIA SOCIAL:

☐ Single/Soltero ☐ Married/Casado ☐ Separated/Separado ☐ Divorced/Divorciado ☐ Widowed/Viudo
Alcoholic Beverages/Bebidas Alcolicas: ☐ Never/Nunca How much/Cuanto_____
Tobacco or Cigarettes/Tobacco o Cigarillos: ☐ Never/Nunca How much/Cuanto_____
Are you sexually active?/Este sexualmente activa? ☐ Yes ☐ No
What is your job?/Cual es su trabajo?_____
Education Level/Nivel de Education: ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 ☐11 ☐12 College/Colegio Supenor: ☐ 1 ☐2 ☐3 ☐4
Race/Raza: ☐Asian ☐Native Hawaiian ☐Other Pacific Islander ☐American Indian ☐White ☐African American ☐More than 1 Race ☐Other
Ethnicity/Étnicidad: ☐ Hispanic/Latino ☐ Not Hispanic/Latino
Primary language (lenguaje primario)_____ Secondary language (lenguaje secundaria)_____

SYSTEMIC REVIEW GENERAL? REVISION DE SYSTEMAS:

Recent weight change?/Reciente cambio de peso?..... No Yes/Si
Have you been in good health most of your life?/Ha tenido buena salud la mayor parte su vida?..... No Yes/Si

HAVE YOU EVER HAD PROBLEMS WITH?/ALGUNA VEZ HA TENIDO PROBLEMAS CON?

Skin/Piel..... No Yes/Si Explain/Explicacion_____
Head-Eyes-Ears-Nose-Throat/Cabeza-Ojos-Oidos-Nanz-Garganta..... No Yes/Si Explain/Explicacion_____
Neck/Cuello..... No Yes/Si Explain/Explicacion_____
Lungs/Pulmones..... No Yes/Si Explain/Explicacion_____
Heart and Circulation/Corazon o Circulacion.... No Yes/Si Explain/Explicacion_____
Blood/Sangre..... No Yes/Si Explain/Explicacion_____
Emotions/Emociones..... No Yes/Si Explain/Explicacion_____
Nerves/Nervios..... No Yes/Si Explain/Explicacion_____
Muscles and Bones/Estomago o Intestinos..... No Yes/Si Explain/Explicacion_____
Sex Organs/Organos Sexuales..... No Yes/Si Explain/Explicacion_____
Urinary/Unnanos..... No Yes/Si Explain/Explicacion_____
Any other/Cualquiera otro..... No Yes/Si Explain/Explicacion_____

ALLERGIES OR REACTIONS TO FOOD/MEDICATION/LATEX? (ALLERGIAS O REACIONES A ALIMENTOS/MEDICINAS/LATEX?)
_____
If applicable, list all current medications (lista de medicamentos actuales)_____
_____

PATIENT SIGNATURE/FIRMA_____ DATE/FECHA_____

DOCTOR SIGNATURE/FIRMA_____ DATE/FECHA_____