**MEDICAL HISTORY SHEET/HISTORIAL MÉDICO**

**Date/Fecha**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Full name/Nombre Completo**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Email Address/Correo Electronico**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Cell Phone/Teléfono Celular**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**#######Please complete all sections. Use N/A if not applicable#######**

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| **MEDICATION/MEDICINA** | **DOSAGE/DOSIS** | **MEDICATION/MEDICINA** | **DOSAGE/DOSIS** |
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**Allergies to Medication/Alergias a medicinas**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Primary Care Physician/Doctor Primario**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Phone/Telefono**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**What pharmacy do you use?/Farmacia** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Where?/¿Dónde?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **SURGERIES and HOSPITALIZATIONS/CIRUGIAS Y HOSPITALIZACIONES** | **DATE/FECHA** |
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**Immunizations/Vacunas:**  **Tetanus/Tétanos (Td/Tdap)** Year/Año \_\_\_\_\_\_ **Pneumonia/Neumonía** Year/Año \_\_\_\_\_\_ **Shingles/Herpes** Year/Año \_\_\_\_\_\_

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| **PERSONAL and FAMILY HISTORY/ HISTORIA PERSONAL Y FAMILIAR (Please specify which family members in the space provided)** | **SELF/ YO** | **Family/**  **Familia** |
| Alcoholism/Alcoholismo |  |  |
| Depression or Anxiety/Depresión o ansiedad |  |  |
| Cancer/Cáncer |  |  |
| Diabetes/Diabetis |  |  |
| Thyroid/Tiroides |  |  |
| Lung Disorders/Trastorno Pulmonar |  |  |
| Clotting Disorders/Enfermedad de la Coagulación |  |  |
| Anemia/Blood Disease/Enfermedad de sangre |  |  |
| Heart Disease/Enfermedad del Corazón |  |  |
| High Blood Pressure/Hipertensión |  |  |
| Mitral Valve Prolapse/Prolapso de la válvula mitral |  |  |
| Intestinal Disorders/Enfermedad de los intestinos |  |  |
| Kidney Disease/Enfermedad del riñon |  |  |
| Liver Disease/Enfermedad del higado |  |  |
| Autoimmune Disorders/Enfermedad de autoinmunidad |  |  |
| Arthritis/Artritis |  |  |
| Osteoporosis |  |  |
| Stroke/Carrera |  |  |
| Migraines or Headaches/Migraña o dolor de cabeza |  |  |
| Sinus or Allergies/Sinusitis o Alergia |  |  |
| Epilepsy or Seizures/Epilepsia o Convulsiones |  |  |
| Glaucoma |  |  |
| Communicable Disease/Enfermedad contagiosa |  |  |
| Other/Otro |  |  |

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| **Social History** | | |
| Marital Status: | Single/Married | |
| Divorced/Widow | |
| Soltero/Casado | |
| Divorciado/Viudo | |
|  |  | |
| Do you use tobacco? | Yes No | Amount: |
| ¿Tabaco? | Si No |
|  |  | |
| Do you use alcohol? | Yes No | Amount: |
| ¿Bebida alcoholica? | Si No |
|  |  | |
| Do you drink caffeine? | Yes No | Amount: |
| ¿Toma café? | Si No |
|  |  | |
| Do you use recreational drugs? | Yes No | Amount |
| ¿Usa drogas? | Si  No |  |
|  |  | |

**Explain/Explique:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature/Firma:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_