

ADULT HEALTH HISTORY / HISTORIA DE SALUD ADULTO

Name/Nombre _____ Age/Edad _____ DOB/Cuando Nacio _____ Date/Fecha _____

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

Measles/Sarampion	<input type="checkbox"/> No	<input type="checkbox"/> Yes/Si	Rheumatic fever/Fiebre Reumatica	<input type="checkbox"/> No	<input type="checkbox"/> Yes/Si
Mumps/Paperas	<input type="checkbox"/> No	<input type="checkbox"/> Yes/Si	Heart Disease/Enfermedad del Corazon	<input type="checkbox"/> No	<input type="checkbox"/> Yes/Si
Chickenpox/Viruela	<input type="checkbox"/> No	<input type="checkbox"/> Yes/Si	Tuberculosis	<input type="checkbox"/> No	<input type="checkbox"/> Yes/Si
Diabetes	<input type="checkbox"/> No	<input type="checkbox"/> Yes/Si	Venereal Disease/Enfermedad Veneria	<input type="checkbox"/> No	<input type="checkbox"/> Yes/Si
Strokes/Embolio	<input type="checkbox"/> No	<input type="checkbox"/> Yes/Si	Serious Disease/Enfermedad Graves	<input type="checkbox"/> No	<input type="checkbox"/> Yes/Si

Ever Hospitalized/Has sido hospitalizado 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 concussions or injuries/
 Golpes o Heridas de cabeza No Yes/Si Explain/Explicacion _____

Date of Last Tetanus Shot/La Fecha de su ultima inmunizacion de Tetano _____

Date of Last PAP Smear/La Fecha de papanicolou exam de cancer. _____

Date of Last Mammogram/Mammografia _____

FAMILY HISTORY/HISTORIA FAMILIAR:

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

Cancer	<input type="checkbox"/> No	<input type="checkbox"/> Yes/Si	Who/Quien? _____
Diabetes	<input type="checkbox"/> No	<input type="checkbox"/> Yes/Si	Who/Quien? _____
Tuberculosis	<input type="checkbox"/> No	<input type="checkbox"/> Yes/Si	Who/Quien? _____
Heart trouble/Enfermedad del Corazon	<input type="checkbox"/> No	<input type="checkbox"/> Yes/Si	Who/Quien? _____
High blood pressure/Presion alta	<input type="checkbox"/> No	<input type="checkbox"/> Yes/Si	Who/Quien? _____
Stroke/Embolio	<input type="checkbox"/> No	<input type="checkbox"/> Yes/Si	Who/Quien? _____
Convulsions/Epilepcia	<input type="checkbox"/> No	<input type="checkbox"/> Yes/Si	Who/Quien? _____
Suicide/Suicidio	<input type="checkbox"/> No	<input type="checkbox"/> 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?/Esta sexualmente activa(o)? Never/Nunca. How much/Cuanto? _____

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 Superior 1 2 3 4

Ethnic Background/Nacionalidad: American Indian Asian Filipino Pacific Islander Black Hispanic White

SYSTEMIC REVIEW GENERAL? REVISION DE SISTEMAS:

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?

Skin/Piel	No <input type="checkbox"/> Yes/Si	Explain/Explicacion _____
Head-Eyes-Ears-Nose-Throat/Cabeza-Ojos-Oidos-Nariz-Garganta	No <input type="checkbox"/> Yes/Si	Explain/Explicacion _____
Neck/Cuello	No <input type="checkbox"/> Yes/Si	Explain/Explicacion _____
Lungs/Pulmones	No <input type="checkbox"/> Yes/Si	Explain/Explicacion _____
Heart and Circulation/Corazon o Circulacion	No <input type="checkbox"/> Yes/Si	Explain/Explicacion _____
Blood/Sangre	No <input type="checkbox"/> Yes/Si	Explain/Explicacion _____
Emotions/Emociones	No <input type="checkbox"/> Yes/Si	Explain/Explicacion _____
Nerves/Nervios	No <input type="checkbox"/> Yes/Si	Explain/Explicacion _____
Muscles and bones/Musculos o huesos	No <input type="checkbox"/> Yes/Si	Explain/Explicacion _____
Stomach and Bowels/Estomago o Intestinos	No <input type="checkbox"/> Yes/Si	Explain/Explicacion _____
Sex Organs/ Organos Sexuales	No <input type="checkbox"/> Yes/Si	Explain/Explicacion _____
Urinary/Urinaros	No <input type="checkbox"/> Yes/Si	Explain/Explicacion _____
Any other/Cualquier otro	No <input type="checkbox"/> Yes/Si	Explain/Explicacion _____

ALLERGIES OR REACTIONS TO FOOD OR MEDICATION/REACCIONES A ALIMENTOS O MEDICINAS

PATIENT SIGNATURE/FIRMA _____

DATE/FECHA _____

DOCTOR SIGNATURE _____

DATE/FECHA _____