HEALTH HISTORY QUESTIONNAIRE (questionario de historia de la salud)

Name (nombre):	☐ **M** ☐ **F**	**DOB**
Previous or Referring Doctor (que doctor lo refiere?):	**Date of Last (Fecha del último examen físico) Physical Exam:**	

PERSONAL HEALTH HISTORY

Past Medical History (historia medica pasada): (Please indicate if (self) or (family) to any of the following) (por favor indica historia de salud familiar y la suya):

Heart Problems (problemas cardíacos):	Lung Cancer (cancer de pulmon):
Diabetes:	Kidney Problems (problemas de riñón):
Vascular:	Other (otro):

History of Cancer in Family (historia de cáncer en la familia):

Type (el tipo):	Relationship (la relación):

Surgeries (la cirugía)**:**

Year (el año)	Reason (la razón)	Hospital (el hospital)

Other Hospitalizations (otro hospitalizations):

Year (el año)	Reason (la razón)	Hospital (el hospital)

List Your Prescribed Drugs and Over-the-Counter Drugs, Such as Vitamins and Inhalers (lista de medicamentos):

Name of Drug (nombre de droga)	Strength (dosis)	Frequency (frequencia)

Allergies to Medications:

Name of Drug	Reaction You Had

HEALTH HABITS AND PERSONAL SAFETY (Habitos de la salud y seguridad personal)

Exercise (ejercicio):
☐ Sedentary (No exercise) ☐ Mild Exercise (i.e., climb stairs, walk 3 blocks, golf)
☐ Occasional Vigorous Exercise (i.e., work or recreation less than 4x/week for 30 min.)
☐ Regular Vigorous Exercise (i.e., work or recreation 4x/week for 30 minutes)

Diet (Dieta):
Are you dieting? ..... ☐ Yes ☐ No
If yes, are you on a physician prescribed medical diet? ..... ☐ Yes ☐ No
# of meals you eat in an average day?_____
Rank Salt Intake ☐ Hi ☐ Med ☐ Low Rank Fat Intake ☐ Hi ☐ Med ☐ Low

Substance Abuse: **(abuso de substancias narcoticas):** History of Substance Abuse? ..... ☐ Yes ☐ No

Alcohol: Do you drink alcohol? ..... ☐ Yes ☐ No

Tobacco (tobacco):
Do you use tobacco? ..... ☐ Yes ☐ No
☐ Cigarettes - Pks/day ☐ Chew - #/day ☐ Pipe - #/day
☐ Cigars - #/day ☐ # of Years ☐ or Year Quit

X

PATIENT/GUARDIAN SIGNATURE DATE