

Nombre: \_\_\_\_\_

Fecha de Nacimiento: \_\_\_\_\_

Fecha: \_\_\_\_\_

Razón de visita: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Tiempo recorrido a esta clínica: \_\_\_\_\_

**PREVIOS DIAGNÓSTICOS DE CANCER**

Tipos de cáncer: \_\_\_\_\_

\_\_\_\_\_

Tratamientos recibidos y dónde: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**HISTORIAL MÉDICO PERSONAL**

Alergias: \_\_\_\_\_

\_\_\_\_\_

Enfermedades / Historial Medical: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Cirugías en el Pasado \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**HISTORIA SOCIAL**

Actualmente Viviendo con: \_\_\_\_\_

Alcohol (Cantidad por semana): \_\_\_\_\_

Uso de Tobacco (Circule): ACTUALMENTE NUNCA EN EL PASADO  
CIGARRILOS CIGAROS TABACO MASCADO

Cantidad que fuma por día \_\_\_\_\_

Qué año empezó \_\_\_\_\_ año que termino \_\_\_\_\_

Utilización de Droga ilegal (Marque): SI NO

**HISTORIAL LABURAL**

Ocupación: \_\_\_\_\_

\_\_\_\_\_

Servicio Militar (pasado o presente): \_\_\_\_\_

\_\_\_\_\_

Algunas Exposiciones a toxinas, vapores, radiación, productos  
químicos (Circule): SI NO Si, de que clase? \_\_\_\_\_

\_\_\_\_\_

**HISTORIAL MÉDICO DE LA FAMILIA**

Favor de incluir padres, abuelos, hermanos, tías y tíos.

**Familiar Enfermedad Edad Diagnostico Vivo/Fallecido(a)**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

NAME: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

REVIEW OF SYSTEMS

CONSTITUTIONAL YES NO
Weight loss in past year
Fever in last month
Night sweats
Fatigue
Appetite change

EYES, EARS, NOSE, THROAT YES NO
Blurred or double vision
Nose bleeds
Hearing loss
Mouth sores
Sore throats
Hoarseness
Trouble swallowing
Sinus problems

RESPIRATORY YES NO
Shortness of breath
Cough
Coughing up blood
Bronchitis
Pneumonia
Emphysema or COPD
Asthma
Blood clots to lung
Flu Shot
Date last received:
Pneumonia Shot
Date received:

CARDIOVASCULAR YES NO
Chest pain
Palpitations
Swelling in feet or legs
High blood pressure
Heart valve disease
Heart murmurs
Coronary artery disease
High cholesterol
Previous heart attack
Congestive heart failure
Irregular heart beat
Blood clots to leg/arm

SKIN YES NO
Rash
Itchiness

GASTROINTESTINAL YES NO
Nausea/ vomiting
Abdominal pain
Liver disease/hepatitis
Peptic ulcers
Diarrhea
Rectal bleeding
Constipation
Colonoscopy
Date last performed:
Sigmoidoscopy
Date last performed:

HEMATOLOGIC YES NO
Anemia
Low platelet counts
Enlarged lymph glands
Abnormal bleeding
Familial thalassemia
Excessive bruising

ENDOCRINE YES NO
Diabetes
Thyroid disease

NEUROLOGICAL YES NO
Headaches
Dizziness
Fainting
Seizures
Difficulty walking
Numbness feet/hands
Stroke

PSYCHOSOCIAL YES NO
Depression
Anxiety
Insomnia
Mental illness
Drug abuse
Alcohol abuse

MUSCULOSKELETAL YES NO
Arthritis
Osteoporosis
Joint pain
New bone pain
Fractures (in past 2 yrs)

GENITOURINARY YES NO
Pain with urination
Blood seen in urine
Bladder infections
Kidney infections/stones
Kidney disease

\*\*MALES ONLY\*\* YES NO
Incontinence
Slow Stream
Dribbling
Erectile Dysfunction
Prostate/Rectal Exam
Date last performed:
PSA drawn
1st result:
Most recent result:

\*\*FEMALES ONLY\*\* YES NO
GYNECOLOGICAL
Fibrocystic ovaries
Fibrocystic breasts
Date of last mammogram:
Any breast biopsies in past
Date of last pap/pelvic exam:
Currently Pregnant
Desire for fertility
# of pregnancies # of children
# spontaneous abortion/miscarriage
# of therapeutic abortions
Breast Feed
Age at first live birth:
Age menstrual periods began
Date of last menstrual period
Menstrual cycle length days
Menopause Status: Pre Peri Post
Age when menopause began
Taking hormonal therapy
How long Type
Taking birth control past or present
How long Type
Number of Living Children

Anything else you would like your doctor to know, please describe below:

Three horizontal lines for writing additional information.