ULTIMA
MEDICAL & AESTHETICS

A Premier Medical Practice!

HEALTH HISTORY

NAME/NOMBRE:________________________________D.O.B./CUAND NACIO:_______________ AGE/EDAD:__________

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-Nariz-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__________________
Muscle and Bones/Musculos o Huesos	No	Yes/Si	Explain/Explicacion__________________
Stomach/Estomago	No	Yes/Si	Explain/Explicacion__________________
Sex Organs/Organos Sexuales	No	Yes/Si	Explain/Explicacion__________________
Urinary/Urinarios	No	Yes/Si	Explain/Explicacion__________________
Any other/Cualquier otro	No	Yes/Si	Explain/Explicacion__________________

Measles/Sarampion	No	Yes/Si	Rheumatic Fever/Fiebre Reumatica	No	Yes/Si
Mumps/Paperas	No	Yes/Si	Heart Disease/Enfermedab del Corazon	No	Yes/Si
Chickenpox/Viruela	No	Yes/Si	Tuberculosis	No	Yes/Si
Diabetes	No	Yes/Si	Venereal Disease/Enfermedad de Veneria	No	Yes/Si
Strokes/Embolio	No	Yes/Si	Serious Disease/Enfermedad Grave	No	Yes/Si
High Blood Pressure	No	Yes/Si			

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______________________________
Ever Been Hospitalized/Ha sido hospitalisado	No	Yes/Si	Explain/Explicacion______________________________
Ever Had Surgery/Ha tenido operaciones	No	Yes/Si	Explain/Explicacion______________________________

Date of Tetnus shot/Fecha de su ultima immunizacion de Tetano ____

FAMILY HISTORY/ HISTORIA FAMILIA
HAS ANYONE IN YOUR FAMILY EVER HAD?/ HABIDO EN SU FAMILIA?

Cancer (**of**)……………………………	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/Epilepcia ……...	No	Yes/Si	Who/Quien______________________________
Suicide/Suicidio……………………...	No	Yes/Si	Who/Quien______________________________

SOCIAL HISTORY/ HISTORIA SOCIAL

Single/Soletero(a) Married/Casado(a) Separated/Seperado(a) Divorced/Divorciado(a) Widowed/Viudo(a)

Alcoholic Beverages/Bebidas Alcolicas	No	Yes/Si	Explain/Explicacion________________________
Do you Smoke/Fuma	No	Yes/Si	Explain/Explicacion________________________
Are you sexually active/Esta sexualmente activo(a)	No	Yes/Si	Are you employed/Está usted empleado? No Yes/Si

Education Level/Nivel de Educacion ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10 ☐11 ☐12 College/Colegio ☐1 ☐2 ☐3 ☐4

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

SYSTEMIC REVIEW GENERAL/ REVISION DE SYSTEMAS

Recent weight changes/Reciente cambio de peso? No Yes/Si

Have you been in good general health most of your life?
Ha tenido Buena salud la mayor parte de su vida? No Yes/Si

CURRENT MEDICATIONS
____
____
____

ALLERGIES OR REACTIONS TO FOOD OR MEDICATION/
ALERGIA O REACCIONES A ALIMENTOS O MEDICAMENTOS____

PATIENT SIGNATURE/FIRMA DEL PACIENTE ______________________________DATE/FECHA______________