CNPMG

Dr. Loveneet Singh (MD), Neurologist
Community Neurology & Pulmonary Medical Group (CNPMG)

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MEDICAL HISTORY/HISTORIA MEDICA

Patient's Name: _____ ***Date of Birth:*** _____
NOMBRE DEL PACIENTE Fecha de nacimiento

PRIMARY CARE PHYSICIAN: _____ ***TODAY'S DATE:*** _____

ALLERGIES TO MEDICATION: _____
Alergias a medicamentos

HEALTH PROBLEMS/PROBLEMAS DE SALUD

Yes SI	No No		Yes SI	No No	
☐	☐	STROKE/Embolio	☐	☐	ALLERGIES/Alergias
☐	☐	HEART DISEASE/Enfermedad de Corazon	☐	☐	KIDNEY DISEASE/Enfermadad de Rinones
☐	☐	HEART ATTACK/Ataque de Corazon	☐	☐	JAUNDICE/HEPATITIS/Ictericia
☐	☐	RHEUMATIC FEVER/Fiebre Reumatica	☐	☐	HIGH BLOOD PRESSURE/Alta Presion
☐	☐	EMPHYSEMA/Pulmonia	☐	☐	CANCER
☐	☐	TUBERCULOSIS	☐	☐	BACK PROBLEMS/Problemas de Espalda
☐	☐	PNEUMONIA	☐	☐	ARTHRITIS
☐	☐	BLEEDING/CLOTTING PROBLEMS/Hemorragia o problemas de coagulacion			
☐	☐	STOMACH/ULCER PROBLEMS/Problema del Estomago o Ulceras			
☐	☐	SPEECH/HEARING PROBLEMS/Problemsas con el habla o esuchando			
☐	☐	DIABETES/ Diabetes	☐	☐	OTHER
☐	☐	BLOOD TRANSFUSIONS/Transfusiones de Sangre	DATES/Fetchas_____		

PREVIOUS SURGERIES, Circle One/CIRUJIAS DE EL PASADO/Circule Uno

DATE/FECHA		DATE/FECHA	
_____	EAR/NOSE/THROAT/Oido/Nariz/Garganta	_____	HYSTERECTOMY/Matris
_____	EYE/Ojo	_____	Hernia
_____	BREAST/Pechos o Seno	_____	HEMORRHOID/Hemorroides
_____	GALLBLADDER/Vesicula Biliar	_____	BACK/NECK/Espalda o Cuello
_____	HEART/VASCULAR/Corazon/Vascularision	_____	JOINTS HIP/KNEE/Rodilla/Cadera

PLEASE TURN OVER TO SIGN
POR FAVOR VOLTEA PARA FIRMAR

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PREVIOUS SURGERIES/ CIRUJIAS DE EL PASADO (Con't)

OTHER/Otro _____

OTHER HOSPITALIZATIONS/Otras estancias en el hospital _____

FAMILY HISTORY/HISTORIA FAMILIAR

_____ HEART DISEASE/Enfermedad de Corazon _____ _____ STROKE/Embolia _____

_____ DIABETES/Diabetes _____ _____ OTHER/Otro _____

_____ HIGH BLOOD PRESSURE/Alta Presion _____

_____ CANCER _____

SOCIAL HISTORY/HISTORIA SOCIAL

DO YOU OR HAVE YOU EVER SMOKED? Fuma o ha fumado en el pasado? Yes/Si ☐ No ☐

HOW MUCH A DAY?Cuanto al dia? _____

DO YOU CONSUME ALCOHOL?Toma bebidas alcoholicas Yes ☐ No ☐

HOW MUCH A DAY? Cuanto al dia? _____

PHARMACY/FARMACIA

NAME/Nombre _____

ADDRESS/Direccion _____

PHONE NUMBER/Numero de telefono _____

CURRENT MEDICATION PRESCRIPTIONS/NOMBRE DE MEDICAMENTOS QUE TOMA

MEDICATION/MEDICAMENTOS