CUESTIONARIO DE SALUD HISTORIAL

Toda las respuestas contenidas en este cuestionario serán mantenidas confidencial y formarán parte de su registro médico.

NOMBRE *(Apellido, Nombre,Segundo Nombre):*		☐Hombre ☐Mujer	**Fecha de Nacimiento:**
Médico previo o remitente:	**Fecha del último examen físico:**		
¿Qué problema medico lo trajo hoy para ser evaluado?			

HISTORIAL DE SALUD PERSONAL

Favor indicar si usted a pasado por las siguientes situaciones o operaciones:

Historia Cardiovascular		**Fecha/Año**	**Hospital**
Infarto de Miocardio (Ataque al Corazón)	☐Sí ☐No		
Cateterismo Cardíaco/Angiograma/Stent	☐Sí ☐No		
Cirugía de Derivación de la Arteria Coronaria	☐Sí ☐No		
Prueba de Esfuerzo en la Banda Continua	☐Sí ☐No		
Ecocardiograma (Ultrasonido del Corazón)	☐Sí ☐No		
Monitor de Holter (verificador de latido irregular)	☐Sí ☐No		
Marcapasos/Desfibrilador	☐Sí ☐No		

Indique cualquier condición médica que otros médicos hayan diagnosticado:

	Fecha de Diagnóstico		**Fecha de Diagnóstico**
☐ Presión Arterial Alta		☐ Otros Diagnóstico	
☐ Colesterol Elevado			
☐ Diabetes			
☐ Arritmia Cardíaca			
☐ Derrame/Embolia			
☐ Enfermedad Arterial Periférica			

Cirugías/Hospitalizaciones

Motivo	**Fecha/Año**	**Hospital**

Catalogar todas la recetas médicas, medicamentos sin receta, vitaminas, suplementos o herbarios nutricionales.

Medicamento	**Dosis**	**Frecuencia**	**Medicamento**	**Dosis**	**Frecuencia**

NOMBRE:	Fecha de Nacimiento:
Allergies or sensitivities (please include IV contrast, x-ray dye, iodine, fish, and /or shellfish)	
Medication	**Reaction You Had**

CARDIAC HISTORY AND SYMPTOMS

Please check and complete the following that pertain to your history:

☐ Rheumatic Fever, what age?	☐ Rheumatic Heart disease, what age?	☐ Scarlet Fever, what age?	
☐ Heart disease at birth, what type?	☐ Heart murmur, first noted when?		
☐ Chest discomfort pain How frequently?	When?	With exercise?	At rest?
☐ Palpitations	☐ Fainting (syncope)	☐ Lightheadedness/dizzy	☐ Shortness of breath with exertion
☐ Sleeping with 2 or more pillows	☐ Shortness of breath that awakens you from sleep	☐ Snoring at night	☐ Cough
☐ Heartburn or GERD	☐ Recent weight gain or loss	☐ Fever	☐ Chills
☐ Nausea	☐ Vomiting	☐ Diarrhea	☐ Sweating
☐ Previous leg vein stripping	☐ Phlebitis	☐ Swelling in the ankles	☐ Leg, buttock or foot pain with walking
☐ Ulcers or sores on you feet	☐ Difficulty with erection or ejaculation	☐ Unusual fatigue	☐ Do you feel depressed

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS	AGE OF DEATH		AGE	SIGNIFICANT HEALTH PROBLEMS	AGE OF DEATH
Father				**Children**	☐ M ☐ F		
Mother					☐ M ☐ F		
Sibling	☐ M ☐ F				☐ M ☐ F		
	☐ M ☐ F				☐ M ☐ F		

SOCIAL HISTORY

Personal	Where were you born?	Current occupation:
	Martial status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed	How many children and their ages?
Exercise	☐ 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	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
Caffeine	☐ None ☐ Tea ☐ Cola ☐ Coffee ☐ Energy Drinks	# Of cups/cans per day?
Alcohol	Do you currently drink alcohol? ☐ Yes ☐ No	If yes how many drinks per week?
	Are you prone to "binge" drinking? ☐ Yes ☐ No	If No, were you a heavy drinker in the past?
Tobacco	Do you use tobacco? ☐ Yes ☐ No	☐ If yes, # of years ☐ If No, # of years quit
	☐ Cigarettes – pks./day	☐ Chew - #/day ☐ Pipe - #/day ☐ Cigars - #/day
Drugs	Do you currently use recreational or street drugs? ☐ Yes ☐ No	

Patient Signature _____ Date _____

Physician Signature _____ Date _____