MEDICAL INFORMATION

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Cual partes del su cuerpo tienen problemas? ____________________

Cuando did it start?____________________ Was it due to an accident?____________

Como begin?____________________

Que empeora el dolor?____________________

Que alivia el dolor?____________________

Que clase de dolor tiene Ud?: Continuou_______ Agudo_______ Aching_______

Burning_______ Sordo_______ Pulsivo________ Otra____________________

Consulta Ud. Otro Medico para este problema?________

Si lo, cual doctores?____________________

Cual tratamientos y medicinas reciba Ud. del doctores?____________________

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Alivian su dolor?____________________

Toma radiografias para este problema?_____________ Si lo, cuando?____________________

Donde?____________________

Cual alergias a medicinas, quemicas o comidas tiene Ud.?

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Are you on a restricted diet?___________

Si lo, explica:____________________

UsaUd. tobaco?__________

Si lo, cuanto?____________________

Toma Ud. Alcohol?___________

Si lo, cuanto ?____________________

Have you taken cortisone in the last year?__________

Have you ever had a fracture?__________

If yes, what and when?____________________

Have you had any surgeries?__________

If yes, what kind and when?____________________

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Check any of the following that you or an immediate family member have ever had:

Condition	You	Family
Lung Problems		
Asthma		
Shortness of Breath		
Tuberculosis		
Anemia		
Bleeding Problems		
Bloody Stools		
Diabetes		
High Blood Pressure		
Colitis		
Stomach Ulcers		
Kidney Problems		
Glaucoma		
Chest Pain		
Heart Attacks		
Brain Surgery or Tumor		
Nervous Problems		
Rheumatic Fever		
Polio		
Neuritis		
Paralysis		
Arthritis		
Other:		

Name:____________________

Date:____________________