



**FAMILY HISTORY/HISTORIA FAMILIAR**

PLEASE MARK WHICH BLOOD RELATIVES HAVE THE FOLLOWING CONDITIONS/POR FAVOR SEÑALE SI ALGUN FAMILIAR TIENE LAS SIGUIENTES ENFERMEDADES

ILLNESS/ENFERMEDAD		M = MOTHER/MADRE F = FATHER/PADRE S = SIBLING/HERMANO(A) AU = AUNT/UNCLE/TIO(A) GP = GRANDPARENT/ABUELO(A)				
ANEMIA	<input type="checkbox"/> YES/SI <input type="checkbox"/> NO	M	F	S	AU	GP
ASTHMA OR ALLERGIES/ASMA O ALLERGIAS	<input type="checkbox"/> YES/SI <input type="checkbox"/> NO	M	F	S	AU	GP
CANCER	<input type="checkbox"/> YES/SI <input type="checkbox"/> NO	M	F	S	AU	GP
CYSTIC FIBROSIS/FIBROSIS QUISTICA	<input type="checkbox"/> YES/SI <input type="checkbox"/> NO	M	F	S	AU	GP
DIABETES/DIABETES	<input type="checkbox"/> YES/SI <input type="checkbox"/> NO	M	F	S	AU	GP
GENETIC DISEASE(BIRTH DEFECTS)/ENFERMEDAD GENETICA(DEFECTOS AL NACER)	<input type="checkbox"/> YES/SI <input type="checkbox"/> NO	M	F	S	AU	GP
HEART ATTACK <50 YEARS OLD/ATAQUE AL CORAZON < 50 AÑOS	<input type="checkbox"/> YES/SI <input checked="" type="checkbox"/> NO	M	F	S	AU	GP
HIGH BLOOD PRESSURE/PRESION ALTA	<input type="checkbox"/> YES/SI <input type="checkbox"/> NO	M	F	S	AU	GP
HIGH CHOLESTEROL NEEDING TREATMENT/COLESTEROL ALTA CON TRATAMIENTO	<input type="checkbox"/> YES/SI <input type="checkbox"/> NO	M	F	S	AU	GP
HYPERACTIVITY/HYPERACTIVIDAD	<input type="checkbox"/> YES/SI <input type="checkbox"/> NO	M	F	S	AU	GP
LEARNING PROBLEMS/PROBLEMAS DE APRENDIZAJE	<input type="checkbox"/> YES/SI <input type="checkbox"/> NO	M	F	S	AU	GP
MENTAL RETARDATION/RETRASO MENTAL	<input type="checkbox"/> YES/SI <input type="checkbox"/> NO	M	F	S	AU	GP
PSYCHIATRIC DISORDER/TRASTORNO PSIQUIATRICO	<input type="checkbox"/> YES/SI <input type="checkbox"/> NO	M	F	S	AU	GP
SEIZURES/CONVULSIONES	<input type="checkbox"/> YES/SI <input type="checkbox"/> NO	M	F	S	AU	GP
SICKLE CELL DISEASE/ANEMIA FALCIFORME(CELULA DE LA HOZ)	<input type="checkbox"/> YES/SI <input type="checkbox"/> NO	M	F	S	AU	GP
SUBSTANCE ABUSE (ALCOHOL/DRUGS/TABACCO)/USO DE(ALCOHOL/DROGAS/TABACO)	<input type="checkbox"/> YES/SI <input type="checkbox"/> NO	M	F	S	AU	GP
TUBERCULOSIS	<input type="checkbox"/> YES/SI <input type="checkbox"/> NO	M	F	S	AU	GP
OTHER/OTRO: _____	<input type="checkbox"/> YES/SI <input type="checkbox"/> NO	M	F	S	AU	GP

**SCHOOL (DAYCARE) BEHAVIOR HISTORY/HISTORIA DE COMPORTAMIENTO EN LA ESCUELA (GUARDERIA)**

CHILD'S SCHOOL NAME/NOMBRE DE ESCUELA: \_\_\_\_\_

GRADE/GRADO: \_\_\_\_\_

 MY CHILD ATTENDS SPECIAL CLASSES OR RECEIVES SPECIAL HELP/MI HIJO(A) RECIBE CLASES ESPECIALES O AYUDA ESPECIAL. EXPLAIN/EXPLIQUE: \_\_\_\_\_ I OR MY CHILD'S TEACHER IS CONCERNED ABOUT HIS BEHAVIOR PROBLEMS/YO O LA MAESTRA ESTAMOS PREOCUPADOS POR EL COMPORTAMIENTO EN LA ESCUELA. EXPLAIN/EXPLIQUE: \_\_\_\_\_

MY CHILD HAS PROBLEMS WITH/MI HIJO(A) TIENE PROBLEMAS CON:

- VISION/VISTA  FREQUENT NIGHTMARES/PESADILLAS FRECUENTES  TROUBLE MAKING FRIENDS/DIFICULTAD HACIENDO AMIGOS  
 HEARING/AUDICION  DIFFICULT TO CONTROL/DIFICIL DE CONTROLAR  FIGHTING A LOT/PELEA MUCHO  
 APETITE/APETITO  BEDWETTING /ORINANDOSE EN LA CAMA  S'TOOLING/HACIENDO DEL BAÑO

**PREVIOUS DOCTOR/DOCTOR ANTERIOR**

NAME OF CHILD'S PREVIOUS DOCTOR/NOMBRE DEL DOCTOR ANTERIOR: \_\_\_\_\_

ADDRESS/DIRECCION: \_\_\_\_\_

ARE THERE ANY OTHER QUESTIONS YOU WANT ANSWERED TODAY/TIENE ALGUNA PREGUNTA PARA EL DOCTOR? \_\_\_\_\_

**SIGNATURE (PERSON COMPLETING THE FORM)/FIRMA (PERSONA QUE LLENO ESTA FORMA) :**

SIGNATURE/FIRMA: \_\_\_\_\_

DATE/FECHA: \_\_\_\_\_

**PROVIDER SIGNATURE/FIRMA DE DOCTOR:**

PROVIDER/DOCTOR: \_\_\_\_\_

DATE/FECHA: \_\_\_\_\_

\* \* \* FOR CLINIC USE ONLY \* \* \*

ANY CHANGES IN HEALTH HISTORY SINCE LAST YEARLY EXAM?

PROVIDER INITIALS

DATE

ANY CHANGES IN HEALTH HISTORY SINCE LAST YEARLY EXAM?	PROVIDER INITIALS	DATE