NASA CASA DE NIÑOS PEDIATRICS NASA
PEDIATRICS, PLLC
HOUSTON TEXAS 77089 PASADENA TEXAS
77504

PATIENT MEDICAL HISTORY/HISTORIAL MEDICO **DATE/FECHA** _____

PATIENT NAME/NOMBRE DE PACIENTE _____

DATE OF BIRTH/FECHA DE NACIMIENTO _____ **PREVIOUS DOCTOR/DOCTOR PREVIO** _____

COMPLETED BY/COMPLETADO POR _____ **RELATIONSHIP TO PATIENT/RELACION AL PACIENTE** _____

BIRTH HISTORY

PREGNANCY
MEDICAL PROBLEMS/PROBLEMAS MEDICOS? ☐ YES/SI ☐ NO
OBSTETRICIAN/GINECOLOGO: _____ HOSPITAL: _____
DELIVERY/PARTO
NORMAL/NORMAL ☐ PROLONGED/PROLONGADO ☐ DIFFICULT/DIFICIL☐ VAGINAL/VAGINAL☐
C-SECTION/CESAREA☐ BREECH/DE PIES☐ VBAC/VAGINAL DESPUES DE CESAREA☐ OTHER/OTRO☐
NEWBORN/RECIEN NACIDO
FULL TERM/TIEMPO COMPLETO☐ PREMATURE/PREMATURO☐ NO. OF WEEKS/NO. SEMANAS _____
TIME OF BIRTH/HORA DE NACIMIENTO _____ BIRTH WEIGHT/PESO AL NACER _____
LEAVING HOSPITAL/SALIDA DEL HOSPITAL
DISCH DATE/FECHA_____ **DISCH. WT/PESO**_____ **PROBLEMS IN NURSERY/PROBLEMAS ☐ YES/SI ☐NO**
GROUP B STREP/STREP GRUPO G ☐ **JAUNDICE/LETERICIA ☐** **OTRO☐** _____
PKU BEFORE DISCHARGE/PKU ANTES DE SALIR ☐ YES/SI ☐ NO
FEEDING/ALIMENTACION: **BREAST/PECHO ☐** **FORMULA/FORMULA ☐**

PAST MEDICAL HISTORY/HISTORIA MEDICA PASADA

HOSPITALIZATIONS/HOSPITALIZACIONES: ☐ YES/SI ☐ NO

DATE/FECHA: _____ RAZON: _____ HOSPITAL: _____
DATE/FECHA: _____ RAZON: _____ HOSPITAL: _____

SURGERY/CIRUGIAS: ☐ YES/SI ☐ NO
AGE/EDAD: _____ REASON/RAZON: _____ HOSPITAL: _____
AGE/EDAD: _____ REASON/RAZON: _____ HOSPITAL: _____

SIGNIFICANT ILLNESSES NOT REQUIRING HOSPITALIZATION/ENFERMEDADES NO HOSPITALIZACION REQUERIDA):
☐ YES/SI ☐ NO LIST/LISTA: _____

ALLERGIES/ALERGIAS ☐ YES/SI ☐ NO
WHICH MEDICINE/CUAL MEDICAMENTO:_____ OTHER/OTRO:_____

IMMUNIZATIONS/VACUNAS
UP TO DATE/AL DIA ☐ DELAYED/ATRASADAS ☐ UNKNOWN/DESCONOSE ☐

PATIENT USE OF/PACIENTE USO DE:
ALCOHOL/ALCOHOL ☐ YES/SI ☐ NO **SMOKES/FUMA** ☐ YES/SI ☐ NO **DRUGS/DROGAS**☐ YES/SI ☐ NO
SEXUALLY ACTIVE/SEXUALMENTE ACTIVO☐ YES/SI ☐ NO **BLOOD TRANSFUSIONS/TRANSFUCIONES DE SANGRE**☐ YES/SI ☐ NO

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REVIEW OF SYSTEMS AND SOCIAL HISTORY/REPASO DE SISTEMAS E HISTORIA SOCIAL

Please check each item "yes" or "no" as it relates to your child's health. *Marque "si" o "no" as it relates to your child's health.*

CONSTITUTIONAL GENERAL	*YES Si*	*NO No*	***CARDIOVASCULAR CARDIOVASCULAR***	*YES Si*	*NO No*		*YES Si*	*NO No*	***NEUROLOGICAL Neurologico***	*YES Si*	*NO No*
Fatigue *Fatiga*	☐	☐	Murmur *Soplo*	☐	☐	Blood in Urine *Sangre en la orina*	☐	☐	Seizures *Convulciones*	☐	☐
Unexplained Fevers *Fiebre Inexplicada*	☐	☐	High Cholesterol *Colesterol Alto*	☐	☐	Bedwetting *Incontinencia Nocturna*	☐	☐	Weakness/Paralysis *Debilidad o Paralisis*	☐	☐
EYES OJOS	☐	☐	Other *Otro*	☐	☐	Abnormal Discharge *Flujo abnormal*	☐	☐	Migraine *Migraña*	☐	☐
Glasses/Contacts *Lentes/Contactos*	☐	☐	***RESPIRATORY RESPIRATORIO***	☐	☐	Age 1st Period _____ *Edad primera menstruacion*	☐	☐	Recurrent Headache *Dolor de Cabeza frequente*	☐	☐
Conjuctivitis *Conjuntivitis*	☐	☐	Chronic Cough *Tos Cronica*	☐	☐	***BLOOD/LYMPH SANGRE/GLANDULAS***	☐	☐	***ALLERGIC/IMMUNOLOIC Sistema Imunologico***	☐	☐
Styes *Orsuelos*	☐	☐	Wheezing *Sibilancia (Pito)*	☐	☐	Easy Bruising *Sangra Facilmente*	☐	☐	Hay Fever *Reaccion alergica al pasto*	☐	☐
EAR, NOSE,THROAT OIDO, NARIZ, GARGANTA	☐	☐	Bronchitis *Bronquitis*	☐	☐	Anemia *Anemia*	☐	☐	Asthma *Asma*	☐	☐
Difficulty Hearing *Problemas de Audicion*	☐	☐	***GASTROINTESTINAL GASTROINTESTINAL***	☐	☐	Large Lymph nodes *Glandulas Engrandecidas*	☐	☐	Recurrent Hives *Urticaria*	☐	☐
Frequent Infections *Infecciones Frecuentes*	☐	☐	Chronic Abdominal Pain *Dolor abdominal Cronico*	☐	☐	***MUSCULOSKELETAL SISTEMA MUSCULAR***	☐	☐	***PSYCHIATRIC SIQUIATRICO***	☐	☐
Nasal Stiffness *Congestion Nasal*	☐	☐	Nausea/Vomiting *Nauseas/Vomito*	☐	☐	Joint Pain/Swelling *Dolor o inchazon de huesos*	☐	☐	Anxiety *Ansiedad*	☐	☐
Chronic Runny Nose *Catarro Cronico*	☐	☐	Constipation *Estreñimiento*	☐	☐	Hip Problems *Problemas de cadera*	☐	☐	Depression *Depresion*	☐	☐
Nose Bleeds Sangrado de Nariz	☐	☐	Diarrhea *Diarrea*	☐	☐	Broken bones *Huesos rotos*	☐	☐	***DEVELOPMENTAL DESAROLLO***	☐	☐
Sinus Trouble *Sinusitis*	☐	☐	***GENITOURINARY GENITAL***	☐	☐	***SKIN/PIEL***	☐	☐	Speech Problems *Problemas al hablar*	☐	☐
Frequent Sore Throats *Dolor de garganta*	☐	☐	Pain Urinating *Dolor al Urinar*	☐	☐	Eczema *Eczema*	☐	☐	Behavioral Problems *Problemas de comportamiento*	☐	☐
Large Tonsils Anginas *Engrandecidas*	☐	☐	Burning/Difficulty Urinating *Quemazon/Dolor al orinar*	☐	☐	Impetigo *Impetigo*	☐	☐	Growth/Development Problems *Problemas crecimiento/desarollo*	☐	☐

SOCIAL HISTORY *Please check as applicable for your child -**HISTORIA SOCIAL** Marque como aplicable a su niño*

SINGLE PARENT HOUSEHOLD *PADRE/MADRE SOLTERO*	☐YES/SI ☐NO ☐N/A
WHO LIVES IN HOUSEHOLD WITH CHILD *QUIEN VIVE CON EL PACIENTE*	☐MOTHER/MADRE ☐FATHER/PADRE ☐SIBLINGS/HERMANOS ☐STEP-PARENT/PADRASTRO ☐OTHERS/OTRO _____
SMOKING IN HOUSEHOLD/*FUMADORES EN CASA*	☐YES/SI ☐NO
CARETAKERS SMOKES? *NIÑERA FUMA?*	☐YES/SI ☐NO ☐N/A
SPLIT CUSTODY/*CUSTODIA COMPARTIDA*	☐YES/SI ☐NO ☐N/A
LIVES IN/ VIVE EN	☐HOUSE/CASA ☐APT/APARTAMENTO ☐TRAILER/CASA MOBIL ☐OTHER/OTRO
DAYTIME CARE/CUIDADO FUERA DE CASA	GRADE/GRADO _____ ☐PRESCHOOL/ESCUELA PRE-ESCOLAR ☐HOME SCHOOL/ENSEÑANSA EN CASA ☐DAYCARE/GUARDERIA ☐TRADITIONAL SCHOOL/ESCUELA TRADICIONAL

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FAMILY/OTHER MEDICAL HISTORY- ***FAMILIAR/OTRO HISTORIAL MEDICO***

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