WELCOME TO THE CARE OF ANNA M. CABECA, D.O., F.A.C.O.G.!
Please fill in this form as completely as possible to enable us to better care for you.

NAME/*Nombre* ________________________________ **SSN#/*Numero de Seguro Social*** ______________ **DATE/*Fecha*** _______

Birth date, *Fecha de nacmiento* _____________ Age, *Edad* _______ Sex, *Sexo*: M F
Address, *Direccion*:
____

Telephone #, *Telefono*, H, *Casa* _________________ W, *Trabajo* _________________
Occupation, *Ocupacion*: Religion, *Religion*:
___________________________________ ___________________________________

Single/*Soltera* Married/*Casada* Divorced/*Divorciada* Widowed/*Conviviente*
Spouse, *Esposo*/Significant other, *su pareja*:________________________ Tel. No._____________________

Please complete this form as completely as possible. *(Por favor llene esta forma completamente o lo mas posible.)*

List all Medications you are currently taking: *(Apuntes cuales medicinas esta tomando ahora):*	**Allergies to Medications, X-Ray Dyes, or other** *(Tiene reaccion alergica o problemas con algunas medicinas?):*
____________________ ____________________ ____________________ ____________________ ____________________ ____________________	____________________ ____________________ ____________________ ____________________
MEDICAL HISTORY	***(HISTORIA MEDICA)***
Mark box and give year onset	*Marke la caja y escriba el ano que le sucedio*
1. Headache or nervous disorder	1. *Dolor de cabeza o desorden nervioso*
2. Thyroid disease	2. *Enfermedad de tiroides*
3. Heart trouble/ Murmur/ High blood pressure	3. *Problemas con el corazon, murmullo, presion alta*
4. Asthma/ lung disorder	4. *Asma/ problemas con los pulmones*
5. Diabetes	5. *Diabetes*
6. Jaundice, hepatitis, other liver disorders	6. *Ictericia, hepatitis, otros problemas con el higado*
7. Stomach, bowel, or gallbladder problems	7. *Problemas del estomago o de la vesicula biliar*
8. Anemia, blood disorder, or blood	8. *Anemia o desorden en la sangre o tranfusion sangre*
9. Arthritis/gout	9. *Artritis, Gota, Serena*
10. Osteoporosis	10. *Osteoporosis*
11. Cancer: Breast/Ovarian/Colon/Cervical/Uterine/other	11. *Cancer: Senos/Ovario/Colon/Cervico/Uterino/Otros*
12. Hereditary or birth defects	12. *Defectos en el nacimiento*
13. Female or sexual problems (Circle): bleeding, fibroids, hysterectomy decreased libido, difficulty with orgasm, pain with sex	13. *Problemas sexuales:* *Sangria, fibromas, histerectomia, flujo vaginal,* *libido disminuirse, dificultad con el orgasmo, dolor en el sexo*
14. Breast problems	14. *Problemas con los senos*
15. Leaking urine/ Incontinence/kidney disease	15. *Incontinencia urinaria*
16. Other medical problems: Are your immunizations current?	16. *Otros problemas medicos*

FAMILY HISTORY Indicate any relatives diagnosed with the above or other illnesses. ***(Historia clinica de la familia)***

Family member	Age/*Edad*	Health condition or problem/ *Problemas*	Other relative/ *Otra familia*	Problem/ *Problemas*
Mother *Madre*				
Father *Padre*				
Grandparents *Abuelos*				
Siblings *Hermanos*				
Children *Hijos*				

Questions you have for the doctor/ *Preguntas para la doctora:*
____
____
____

LIST ALL HOSPITALIZATIONS/OPERATIONS *Apunte todo los hospitales y operaciones*			
Date *Fecha*	Doctor or Hospital	Operation/Illness *Operacion/ enfermedad*	Complications *Complicationes*

OBSTETRIC HISTORY: *Historia Obstetrica:*			
Date Fecha	Doctor or Hospital	Outcome (Vag, C/S, Miscarriage): *Tipo de Parto (vaginal, cesarean, aborto)*	Complications *Complicaciones*

GYNECOLOGIC HISTORY

When was the first day of your last menstrual period? __/__/__
Age you first started periods: _______
Your period starts every: _______days.
How many days do your periods last: _________ Heavy/Med./Light
Do you have cramps with your periods? No Yes
Do you have PMS or other? No Yes
History of abnormal pap smear? No Yes
When? _____________
Treatment type: ______________________________
Method of Birth Control: ___________________________

How old were you when you became sexually active? _____
Number of sexual partners ever:
Please circle if you have had the following : yeast, trichomonas, bacterial vaginosis, gonorrhea, chlamydia, syphilis, herpes, HIV, genital warts, pelvic inflammatory disease (PID)
Have you ever been a victim of sexual abuse?
Age at menopause: _____ Taking hormones: No Yes

When was your last:
Pap smear? __________ Breast exam? __________
Mammogram? ________ Dexascan? ___________
Cholesterol check? ____ Stool check for blood?____

HISTORIA GINECOLOGIA

Quando fue el primer dia de su ultima regla? __/__/__
Edad de su primera menstruacion: _______
Su periodo empieza cada _______ dias
Por cuantos dias dura su menstruacion? ________
Tienes reglas dolorosas? *No* *Si*
Tienes sintomos pre menstrual (depresion)? *No* *Si*
Historia anormal de pap? *No* *Si*
Cuando? _____________
Tipo de Tratamiento: _______________________
Metodo de planificar para tener o no tener familia: ________________

Cuantos anos tenia usted cuando empezo hacense activa suxualmente?
Cuantos comaneros sexuales?
Por favor ponga un circulo si ha tenido alguno de los siquentes: fermento, verrugas, granos, siphilis, herpes, HIV, tricomonas

(Abuso sexual)?
Edad de menopausia: ______ *Toma hormonas?* *No* *Si*

Fecha de su ultimo control:
Papinocolao _______________ *Examen de senos? _____*
Mammografia?_______ *Dexascan? ___________*
Colesterol? ___________ *Sangre en el recto? _____*

SOCIAL HX/ PREVENTION:	No	Yes	How much?		*No*	*Si*	*Cuantos?*
Do you smoke cigarettes				*Fuma cigarros o cigarillos?*			
Have you ever smoked? For how many years?				*Por cuantos anos?*			
Do you drink alcoholic beverages?				*Toma bebidas con alcohol?*			
Do you drink caffeinated beverages?				*Toma bebidas con cafeina?*			
Do you use drugs?				*Consuma drogas?*			
Do you ever feel afraid of your partner?				*Tiene usted miedo de su comanero?*			

Review of Systems (circle all that apply)

Gen sx	neg	fever, chills, wt loss/gain, fatigue
Eyes	neg	glasses, glaucoma, cataracts, blurred vision
ENT	neg	hearing loss, sinus trouble, sore throats
Heme	neg	anemia, bleeding problems, blood thinners
Card	neg	palpitations, chest pain, murmur
Resp	neg	shortness of breath, wheezing, cough
Neuro	neg	dizziness, tremors, headaches
Psych	neg	depression, anxiety attacks, stress
Endo	neg	hot flashes, changes in sleep patterns, hair loss
Breast	neg	tenderness, mass, discharge
GI sx	neg	abdominal pain, nausea, vomiting, constipation, diarrhea
Ren/GU	neg	burning with urination, bloody urine, loss of urine with urge/cough/sneeze, waking up at night to urinate
Gyn	neg	vaginal discharge, cramps, pain with sex, heavy periods, midcycle spotting, decreased libido