NASA CASA DE NIÑOS PEDIATRICS NASA PEDIATRICS, PLLC

HOUSTON TEXAS PASADENA & TEXAS CITY

**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**

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| **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**

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| **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 |

**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.*

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| **CONSTITUTIONAL**  **GENERAL** | *YES NO*  *Si No* | ***CARDIOVASCULAR***  ***CARDIOVASCULAR*** | *YES NO*  *Si No* |  | *YES NO*  *Si No* | ***NEUROLOGICAL***  ***Neurologico*** | *YES NO*  *Si 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* | *🗖 🗖* |
| *Nosebleeds*  *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 orinar* | *🗖 🗖* | 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*

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| 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 |

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

***\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***