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 🗖 NOOBSTETRICIAN/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 🗖 NODATE/FECHA: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ RAZON: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ HOSPITAL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE/FECHA: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ RAZON: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ HOSPITAL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**SURGERY/CIRUGIAS:** 🗖 YES/SI 🗖 NOAGE/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 🗖 NOWHICH 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 TonsilsAnginas *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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

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