CECIMP
CENTRO DE CIENCIA Y MEDICINA PREVENTIVA

Medical Director: Dr. Juan Enrique Perea

Patient History
To be completed by the patient

Last name: _________________ First name: _______________________________
ID number: __________________ Date of birth: dd ____/mm_________/yy_______
Address: _______________________City: _____________Country:_____________
Home Telephone: ______________________ Cell phone: ____________________
Email:____________________@_______________________

HAVE YOU EVER BEEN TREATED FOR AND/OR NEED FOLLOW-UP FOR ANY OF THE CONDITIONS LISTED BELOW?
PLEASE MARK (√) ALL OF THE ONES THAT APPLY TO YOU AND ADD COMMENTS BELOW

- ☐ Eye problems
- ☐ Glasses / contacts
- ☐ Headaches/migraines
- ☐ Dizziness/fainting spells
- ☐ Seizures/Epilepsy
- ☐ Ear infections
- ☐ Hearing loss
- ☐ Hearing aid (s)
- ☐ Nose bleeds
- ☐ Asthma / Emphysema
- ☐ Bronchitis
- ☐ Pneumonia
- ☐ Tuberculosis
- ☐ Shortness of breath
- ☐ Pauses of breathing while sleep, loud snoring, daytime sleepiness
- ☐ Allergies
- ☐ Hay fever
- ☐ Skin problems / rashes
- ☐ High blood pressure
- ☐ Heart surgery / Bypass
- ☐ Stroke or paralysis
- ☐ Diabetes: Type 1 / 2
- ☐ Thyroid problems
- ☐ Stomach pains
- ☐ Ulcers
- ☐ Acid reflux
- ☐ Chronic vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Gallbladder
- ☐ Arthritis
- ☐ Dislocated or broken bones
- ☐ Amputations / prosthetics
- ☐ Neck: pain / injury / surgery
- ☐ Shoulder: pain / injury / surgery
- ☐ Back: pain / injury / surgery
- ☐ Hip: pain / injury / surgery
- ☐ Knee: pain / injury / surgery
- ☐ Hernias of any kind
- ☐ Mental or nervous disorders
- ☐ Anxiety / Depression
- ☐ Eating disorders
- ☐ Alcohol or drug abuse
- ☐ Smoke. Cigarettes a day: ______________
- ☐ Benign tumors
- ☐ Breast lumps / masses
- ☐ Cancer type:_________
- ☐ Anemia / blood disorders
- ☐ Menstrual problems
- ☐ Hepatitis B / C
- ☐ Kidney stones
- ☐ Urinary infections
- ☐ Genital herpes
- ☐ HIV
- ☐ Syphilis / Gonorrhea
- ☐ Venereal warts
- ☐ Prostate problems

☐ Heart diseases or heart attack
☐ Varicose veins: surgery
☐ Hemorrhoids
☐ Chest pain
☐ Swelling to arms or legs
☐ Rectal bleeding

Please give a short history for any of the boxes you checked:

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What medications do you take on a routine basis?

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____

____

What operations have you had and when?

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Have you ever been in the hospital? If yes: why and when?

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For female only:
Date of the last PAP: ________________ Date of the last mammogram: _________________
Do you have any problem with your menstrual cycle? ☐ Yes ☐ No
Date of your last period: ___________________________

Please provide us with a description of any problems you have had in the past that were not addressed on these pages:

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I have read the lists above and marked all that apply. Signature: _______________________

Date: dd ____/mm________/yy______

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Medical Director: Dr. Juan Enrique Perea

Physical Examination

To be completed by the examining physician: Please circle and check all that apply

Last name: ___________________ First name: __________________________________

ID number: _____________________Date of birth: dd ____/mm_________/yy______

Height:__________ Weight: ___________ BMI: ____________

Temp: __________ Pulse: ___________ BP: _________/__________mmHg

Eyes			**Skin**			**Gastrointestinal**		
L: 10/____ Corrected 10/____			Lesions	Yes	No	Ulcers	Yes	No
R: 10/____ Corrected 10/____			Scars	Yes	No	Acid reflux	Yes	No
Color Blindness	Yes	No	Birthmarks	Yes	No	Abdominal pains	Yes	No
• Red / Green	Yes	No	Jaundice	Yes	No	Nausea / Vomiting	Yes	No
• Yellow / Blue	Yes	No	Discolorations	Yes	No	Diarrhea	Yes	No
Pterygium	Yes	No	Eczema	Yes	No	Constipation	Yes	No
Glaucoma	Yes	No	Psoriasis	Yes	No	Abnormal Bowel sounds	Yes	No
Cataracts	Yes	No	Lymphomas	Yes	No	Hepatomegaly	Yes	No
Conjunctivitis	Yes	No	Tattoos	Yes	No	Splenomegaly	Yes	No
Exophthalmia	Yes	No	Ganglion cyst	Yes	No	Hernias	Yes	No
Retinopathy	Yes	No	**Cardiovascular**			Hemorrhoids	Yes	No
Ears			Heart disease	Yes	No	Hepatitis A	Yes	No
Otitis media	Yes	No	Palpitations	Yes	No	Hepatitis B	Yes	No
Otitis externa	Yes	No	Chest pain	Yes	No	Hepatitis C	Yes	No
Tumor / Masses	Yes	No	Pacemaker	Yes	No	**Musculoskeletal**		
Hearing los	Yes	No	By-pass	Yes	No	Osteoarthritis	Yes	No
Abn. Whisper test	Yes	No	Arrhythmias	Yes	No	Rheumatoid arthritis	Yes	No
Nose			Hypertension	Yes	No	Joint pains	Yes	No
Septal deviation	Yes	No	Congestive failure	Yes	No	Gout	Yes	No
Nasal Polyps	Yes	No	Cardiomegaly	Yes	No	Muscle weakness	Yes	No
Epistaxis	Yes	No	Dyspnea on exertion	Yes	No	Muscle cramps	Yes	No
Nasal fractures	Yes	No	Pedal edema	Yes	No	Muscle stiffness	Yes	No
Snoring	Yes	No	Varicose vein	Yes	No	Deformities	Yes	No
Tonsilitis	Yes	No	Homan's sign	Yes	No	Injury/Pain/Surgery of:		
Dental			Abnormal EKG	Yes	No	• Back/Neck	Yes	No
Bad hygiene	Yes	No	**Males**			• Shoulder/Arm/Wrist	Yes	No
Cavities	Yes	No	Epididymitis	Yes	No	• Knee/Leg/Ankle	Yes	No
Gingivitis	Yes	No	Orchitis	Yes	No	**Emotional**		
Mouth sores	Yes	No	Hypo/Hyperspadias	Yes	No	Insomnia	Yes	No
Respiratory			Varicocele	Yes	No	Depression	Yes	No
Asthma	Yes	No	Scrotal hernia	Yes	No	Anxiety	Yes	No
Bronchitis	Yes	No	Prostatomegaly	Yes	No	Hallucinations	Yes	No
Emphysema	Yes	No	**Females**			Eating disorders	Yes	No
Pneumonia	Yes	No	Amenorrhea	Yes	No	**Labs / Test**		
Constant cough	Yes	No	Dysmenorrhea	Yes	No	RBC		
Sputum production	Yes	No	Menorrhagia	Yes	No	WBC		
Tuberculosis	Yes	No	Menopause	Yes	No	Glucose		Mg
Abnormal breath sounds	Yes	No	Vaginal Discharge	Yes	No	BUN		Mg
Abnormal X ray	Yes	No	Breast exam: lumps	Yes	No	Creatinine		Mg
Endocrine			**Genitourinary**			Cholesterol		Mg
Diabetes (1 / 2)	Yes	No	Kidney stones	Yes	No	LDL		Mg
Thyroid problems	Yes	No	Recurrent UTI's	Yes	No	HDL		Mg
Neuro			Urinary frequency	Yes	No	Triglycerides		Mg
Abnormal Cranial nerves	Yes	No	Pain on urination	Yes	No	SGOT		U

Abn. Peripheral nerves	Yes	No	Hematuria	Yes	No	SGPT		U
Tremors / Seizure	Yes	No	Nocturia	Yes	No	Bilirubin		Mg
Vertigo / Ataxia	Yes	No	Venereal warts	Yes	No	Urinalysis		

Please document and comment on all abnormal test results and physical findings:

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Date of exam: dd ____/mm________/yy______

Examining physician:

Last name: _________________ First name: ______________________________

Signature:___________________________ Stamp:______________________________