



UDLA Health Services 2007
Centro Internacional de Lengua y Cultura

Please fill-out this form carefully. The information here-in contained will become part of your clinical history and will be confidential. It will not in any way affect your status at the university.

 Last Name Middle Name First Name Age

Gender: M F

In case of emergency please call:

 Name & Relationship Telephone

Family History

Father Living Dead Occupation _____

Mother Living Dead Occupation _____

Siblings Living 0 1 2 3 4 more

Dead 0 1 2 3 4 more

Have you or any blood relatives had:

	Yes	No		Yes	No
Tuberculosis	()	()	Arthritis	()	()
Diabetes	()	()	Hay fever	()	()
Stomach problems	()	()	Asthma	()	()
Intestinal problems	()	()	Seizures	()	()
Heart disease	()	()	Convulsions	()	()
Kidney problems	()	()	High blood pressure	()	()
Cancer, tumor, etc	()	()	Syphilis	()	()

Have you ever had? Please answer all questions. Comment all positive answers

	Yes	No		Yes	No
Scarlet fever	()	()	Allergies		
Measles (red)	()	()	Penicillin	()	()
Measles (German)	()	()	Sulfa drugs	()	()
Mumps	()	()	Serum	()	()
Chicken pox	()	()	Salicylic acid, aspirin	()	()
Malaria	()	()	Hives	()	()
Anemia	()	()	Other (note below)	()	()
Gum/tooth trouble	()	()	Surgery		
Sinusitis	()	()	Appendectomy	()	()

