**Familia / Family Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PATIENT INFORMATION SHEET**

Name/Nombre:

Date/Fecha: Age/Edad: Sex/Sexo:

Community/Comunidad:

When did you last visit a doctor/nurse?

Cuando fue la ultima vez que visitó un médico/enfermera?

Days/Días Weeks/Semanas Months/ Meses Years/Anos Where/Adonde?

How did you get here today? como llego aquí el día de hoy? on foot / a pie

Public transportation / transporte publico Personal Vehicle / Carro particular

Education Level?/Nivel Educativo Primary/Primaria High School/Bachiller University/Universidad

Allergic to medicines/Alérgico(ca) a alguna medicina; Yes/si No

Current medication / Medicinas que esta tomando;

***Breast/feeding/ Dando pecho Yes/si No Pregnant/Embarazada*** Yes/si No

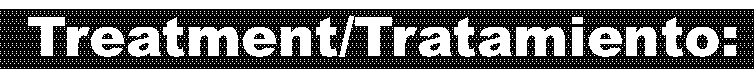
Height/Estatura; Weight/Peso: Temperature/Temperatura;

Blood Pressure/Presion Arterial; Pulse/Pulso; Respirations;

Chief Complaint/Queja Principal;

Chronic Problem?/ Problema cronico

Diagnostico;



󠅦 Vitamins Vitaminas \_

󠅦 Acetaminophen/Acetaminofen \_

󠅦 Antacid/Antiacido \_

󠅦 Topica/Topico \_

󠅦 Ibuprofen \_

󠅦 Albendazole \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

󠅦 Antibiotic */*Antibioticos \_

Other/Otros: \_

Health Education:

󠆶 Referral/RemisiÓn:

**Signature *I* Firma**

Group: \_