**INFORMACION DE PACIENTE**

**Nombre:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Nacimiento:** \_\_\_\_\_\_\_\_\_\_\_\_ **Edad:** \_\_\_\_ **Sexo:** M o H

**Numero de Seguridad Social:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Casado:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Raza:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Preferred Language:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Direcion:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Ciudad:** \_\_\_\_\_\_\_**Estado:** \_\_\_\_ **Zip Code:**\_\_\_\_\_\_\_\_\_\_

**Telefono:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Cell:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Trabajo:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**E-Mail Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Ocupaion/Employer:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **ALTURA:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **PESO:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**INFORMACION DE PADRES**

**Madre:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Nacimiento:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Numero Social:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Direcion:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Ciudad:** \_\_\_\_\_\_\_\_\_**Estado:** \_\_\_\_ **Codigo**\_\_\_\_\_\_\_

**Telefono:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Cell:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Trabajo:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Padre:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Nacimiento:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Numero Social:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Direcion:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Ciudad:** \_\_\_\_\_\_\_\_**Estado:** \_\_\_\_ **Codigo:**\_\_\_\_\_\_\_

**Telefono:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Cell:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Trabajo:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**INFORMACION DE SEGURIDAD**

**Primario:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Segundario:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Nombre Responable (Primario):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Naciemento:** \_\_\_\_\_\_\_\_\_\_\_\_\_

**Nombre de Responable (Segundario):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Nacimiento:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**INFORMATION DE REFERENCIA**

**Quien le mando referencia?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Doctor Primario:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Telefono:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HISTORIAL MEDICO (marque todos que apliquen)**

|  |  |  |  |
| --- | --- | --- | --- |
| AnsiedadAsmaArtitisCancer \_\_\_\_\_\_\_\_\_\_\_\_ Cholesterol AltaPulmonar(COPD) | DepresionDiabetesEnfermedad RenalEnfermedad de CorazonHepatitis | SIDA/ AIDSPresion AltaHipotiroidismo (Baja)Hipertirodismo (Alta)Leucemia | LinfomaRadiacionConvulsionesStroke |

**Otro:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Cirugias Pasadas (marque todos que aplica)**

|  |  |  |
| --- | --- | --- |
| Transplante Medula Osea Lumpectomia (D, I, Dos) Mastectomia (D, I, Dos)Bypass Arteria CoronariaReemplazo Valvula Biologica | Reemplazo Valvula MecanicaTransplante de CorazonReemplazo de Cadera(D, I,Dos)Remplazo de Rodilla (D, I, Dos)Rinion Extraccion (D, I, Dos) |  Transplante de Rinion Transplante de HigadoHisterectomia  |

**Otro:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Histroria de la piel (marque todos que aplica)**

|  |  |  |  |
| --- | --- | --- | --- |
| AcneActinic KeratosisBasal Cell Skin Cancer | Piel SecaEczemaFlaking/Picazon de Cabeza | Hay Fever / AllergiesMelanomaPrecancerous Moles | PsoriasisSquamous Cell  Cancer de Piel |

**Otro:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Usa Sol Protector? □** Si **□** NoQue SPF:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Va a salon de Bronseado?** □ Si □ No

**Historia familiar de Melanoma Maligno:** □ Si □ No

Si, Quienes?: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICAMENTOS**

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**ALERGICAS (TODOS LOS TIPOS Y REACIONES)**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Farmacia preferencia:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Direcion:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Ciuda:** \_\_\_\_\_\_\_\_\_\_ **Estado:** \_\_\_\_ **Codigo:** \_\_\_\_\_\_\_\_\_\_

**Phone:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Fax:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ALERTAS (marque todos que aplica)**

|  |  |  |
| --- | --- | --- |
| Alergia a AdhesivoAlergia a LatexAlergia a LidocainaReemplazo de Valvula Artificial Reemplazo de Juntas | Problemas de SangrandoAnticoagulantesDesfibiladorCicatriz QueliodeMRSA | MarcapasosProblemas con curacion Require Antibioticos antes de suregiasCorazon rapida con Epinefrina |

**Esta embarazada o intentando quedar embarazada?** □ Si □ No

**Esta amamantando actualmente?** □ Si □ No

**Consumo de Tobacco:** □ Nunca □ Fumador □ Ex Fumador

**Para Fumadores:** □ 1-3 cigarillos por dia □ 1 paquete por dia □ Mas de un paquete por dia

**Uso de alcohol:** □ Nunca □ Menos de una por dia □ 1-2 bebidas por dia □ Mas de 3 al dia

**Vaccinaciones:** Desde October 1st, 2021 y hoy, recibio las siguientes vacunas?

 Flu Vaccine: □ Si □ No

 Pneumonia Vaccine: □ SI □ No

**65yo o mas:** Tiene uno de los siguientes?

 □ Poder Notarial (sustituto para decisions medico) □ Testamento en vida

 □ Ninguno

 Nombre / Relacion: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **PERMISO DE RECORDS PERSONALES**

Yo (su nombre), \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, doy permiso a Lux Dermatology para dar cualquier informacion que me pertenezca a:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Nombre y Relacion Telefono

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Nombre y Relacion Telefono

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Nombre y Relacion Telefono

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Nombre y Relacion Telefono

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Nombre y Relacion Telefono

Nombre de paciente): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Nacimiento: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Firma de paciente/ guardian Fecha