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Name: _____ Date of Birth: _____ Date: _____

Family History: Circle all that apply

- | | | | |
|------------|---------------------|--------------------|-------|
| Alcoholism | Diabetes | Kidney Disease | _____ |
| Anemia | Epilepsy | Migraine Headaches | _____ |
| Asthma | Glaucoma | Osteoporosis | _____ |
| Arthritis | Heart Disease | Stroke | _____ |
| Cancer | High Blood Pressure | Thyroid | _____ |

Hospitalizations / Surgeries:

Year	Illness / Surgery

Allergies to Medications: None

- Penicillin _____ Sulfa _____ Codeine _____
 Other: _____

Social Habits:

- Smoking: _____ packs/cigs per day
 Alcohol: _____ oz/week
 Coffee: _____ cups/day

Medications (dosage & frequency):

Vaccinations

Date Given

Test/Exam

Date

1. _____	Tetanus/Diphtheri	_____	TB Skin Test	_____
2. _____	Influenza	_____	Cholesterol	_____
3. _____	Pneumonia	_____	Colonoscopy	_____
4. _____	Hepatitis A	_____	EKG	_____
5. _____	Hepatitis B	_____	Chest X-ray	_____
6. _____	MMR	_____	Treadmill Stress Test	_____
7. _____	Meningitis	_____	Physical Exam	_____

Medical History: Circle all that apply

- | | | | |
|-------------------------------|--------------------------------|-------------------------------|--|
| Anemia | Gout | Sleeping Difficulty | Men Only:
PSA _____
Prostate Exam |
| Asthma/Wheezing | Heart Murmur | Stroke | |
| Abdominal Pain (chronic) | High Blood Pressure | Thyroid Disease | Other:

_____ |
| Allergies | Hernia | Tuberculosis | |
| Bronchitis / chronic cough | Hemorrhoids | Urethral Discharge | |
| Bloody or Tarry Stools | Heartburn / Indigestion | Urinary Infections (frequent) | _____ |
| Blurred or double vision | Hepatitis | Ulcers | _____ |
| Chest Pain | Hoarseness (prolonged) | | _____ |
| Constipation | Herpes | | |
| Colitis | Irregular Pulse / Palpitations | Females Only: | |
| Cancer | Loss of Appetite (recent) | # of pregnancies: _____ | |
| Depression / Anxiety | Leg Pain—walking | # of abortions: _____ | |
| Diverticulitis/Diverticulitis | Pneumonia | # of miscarriages: _____ | |
| Diabetes | Shortness of Breath | # of live births: _____ | |
| Diarrhea | On Exertion | Last Menstrual Period: _____ | |
| Difficulty Swallowing | Lying Flat | Last Pap Smear: _____ | |
| Dizzy Spells | Sore Throat (recurrent) | Last Mammogram: _____ | |
| Ear Infections (frequent) | Sinus Trouble | Last Bone Density: _____ | |
| Fainting Spells | Swollen Ankles | | |

Signature