



¿Ha tenido alguna vez? Conteste a todas las preguntas. Comente abajo todas las respuestas positivas.

	Sí	No		Sí	No
Escarlatina	⊕	⊕	<b>Alergias</b>	⊕	⊕
Sarampión	⊕	⊕	Penicilina	⊕	⊕
Rubéola	⊕	⊕	Sulfas		⊕
Paperas	⊕	⊕	Sueros		⊕
Varicela	⊕	⊕	Ac. Acetil Salicílico		⊕
Malaria	⊕	⊕	Urticaria		⊕
Anemia	⊕	⊕	Otras (anote abajo)		⊕
Problemas con encías o dientes	⊕	⊕			⊕
Sinusitis	⊕	⊕	<b>Cirugías</b>		⊕
Problemas oculares	⊕	⊕	Apéndice		⊕
Problemas óticos	⊕	⊕	Anginas		⊕
Problemas laringológicos	⊕	⊕	Hernia		⊕
Gripes continuas	⊕	⊕	Otras (anote abajo)		⊕
Asma	⊕	⊕			⊕
Golpes en la cabeza	⊕	⊕	Insomnio		⊕
Dolores de cabeza continuos	⊕	⊕	Ansiedad/depresión		⊕
Disnea (falta de aire)	⊕	⊕	Preocupación/nervios		⊕
Dolor de pecho / presión	⊕	⊕	Epilepsia		⊕
Tos crónica	⊕	⊕			⊕
Palpitaciones	⊕	⊕	Problemas digestivos		⊕
Fiebre reumática	⊕	⊕	Diarrea continua		⊕
Enfermedad de las articulaciones	⊕	⊕	Hernia		⊕
Fracturas	⊕	⊕	Pérdida o aumento de peso reciente		⊕
Problemas de espalda	⊕	⊕	Mareos, desmayos		⊕
Tumores, quistes, cáncer, etc.	⊕	⊕	Debilidad, parálisis		⊕
Ictericia	⊕	⊕	Enfermedades venéreas		⊕
Hepatitis	⊕	⊕	Micción frecuente		⊕
Problemas de la vesícula biliar	⊕	⊕	<b>Mujeres Solamente</b>		
			Periodos irregulares		⊕
			Cólicos severos		⊕
			Flujo excesivo		⊕

¿Ha sido restringida su actividad física durante los últimos cinco años?

Dé razones y duración: \_\_\_\_\_

¿Qué medicamentos toma actualmente? \_\_\_\_\_

¿Ha recibido tratamiento por problemas emocionales, nervios o personalidad perturbada, durante los últimos cinco años? Sí No  
⊕ ⊕

¿Ha sido rechazado por el Servicio Militar por causas físicas, emocionales u otras? ⊕ ⊕

¿Tiene alguna pregunta con respecto a su salud, su historia familiar, u otro asuntos que le gustaría discutir con algún miembro del personal del servicio de salud? ⊕ ⊕

#### Exploración física

Agudeza visual: Der. 20/ \_\_\_\_\_ Izq. 20/ \_\_\_\_\_  
 Talla \_\_\_\_\_ Mts. \_\_\_\_\_ Peso \_\_\_\_\_ Kg.  
 Temp. \_\_\_\_\_ °C \_\_\_\_\_ FC. \_\_\_\_\_ / min TA. \_\_\_\_\_ / \_\_\_\_\_ mm Hg.

¿Hay alguna irregularidad en los siguientes sistemas?

Respiratorio	⊕	⊕
Cardiovascular	⊕	⊕
Gastrointestinal	⊕	⊕
Genitourinario	⊕	⊕
Musculoesqueletico	⊕	⊕
Endócrino	⊕	⊕
Neuropsiquiátrico	⊕	⊕
Piel y faneras	⊕	⊕

¿Tiene algún comentario general?

¿Tiene alguna recomendación en relación al cuidado de la salud del estudiante?

¿Necesita tratamiento actualmente por algún problema físico o emocional?

\_\_\_\_\_  
Firma estudiante

\_\_\_\_\_  
Firma del médico

\_\_\_\_\_  
Reg. S.S.A. Y D. G. P.

**"UNIVERSITY HEALTH SERVICES"**  
 UNIVERSIDAD DE LAS AMERICAS, PUEBLA  
 STA. CATARINA MÁRTIR, CHOLULA  
 PUEBLA, 72820 MÉXICO

**Important**

Use ball-point pen and print or type. Incomplete information may delay processing of your application.

This form is required for the health insurance policy automatically issued to all students

PLEASE FILL-OUT FORM CAREFULLY BEFORE TAKING TO YOUR PHYSICIAN. THE INFORMATION HERE-IN CONTAINED WILL BE CONFIDENTIAL. IT WILL NOT IN ANY WAY EFFECT YOUR STATUS AT THE UNIVERSITY

\_\_\_\_\_ Date \_\_\_\_\_

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Last Name	Mother's Maiden Name	First Name	Age
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Address (Street & Number)	City	State	Country	ZIP code	Telephone
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Name & Relationship of next of kin \_\_\_\_\_

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Address (Street & Number)	City	State	Country	ZIP code	Telephone
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Nationality _____	Sexo	F	<input type="radio"/>	M	<input type="radio"/>
Marital status	Single	<input type="radio"/>	Married	<input type="radio"/>	Divorced
		<input type="radio"/>		<input type="radio"/>	Other _____

**Family History**

<b>Father</b>	<b>Mother</b>
living / dead	living / dead
occupation: _____	occupation: _____

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**Siblings**

living	0	1	2	3	4	ó más
dead	0	1	2	3	4	ó más

**Have you or any blood relatives had:**

	Yes	No	Yes	No
Tuberculosis	<input type="radio"/>	<input type="radio"/>	Arthritis	<input type="radio"/>
Diabetes	<input type="radio"/>	<input type="radio"/>	Hay fever	<input type="radio"/>
Stomach problems	<input type="radio"/>	<input type="radio"/>	Asthma	<input type="radio"/>
Intestinal problems	<input type="radio"/>	<input type="radio"/>	Seizures	<input type="radio"/>
Heart disease	<input type="radio"/>	<input type="radio"/>	Convulsions	<input type="radio"/>
Kidney problems	<input type="radio"/>	<input type="radio"/>	High blood pressure	<input type="radio"/>
Cancer, tumors, etc.	<input type="radio"/>	<input type="radio"/>	Syphilis	<input type="radio"/>

Observation (to be filled by the doctor)

Observation (to be filled by the doctor)

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

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

**Physical examination**

<b>1.Baar</b>	( ) _____
<b>2.Blood test</b>	( ) _____
<b>3.Blood chemistry</b>	( ) _____
<b>4.V.D.R.L. test</b>	( ) _____
<b>5.Hepatitis</b>	( ) _____
<b>6.General urine</b>	( ) _____
<b>7.Blood group and RH</b>	( ) _____
<b>8.HIV (optional)</b>	( ) _____

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

	Yes	No		Yes	No
Scarlet fever	<input type="checkbox"/>	<input type="checkbox"/>	<b>Allergies</b>	<input type="checkbox"/>	<input type="checkbox"/>
Measles (red)	<input type="checkbox"/>	<input type="checkbox"/>	Penicillin	<input type="checkbox"/>	<input type="checkbox"/>
Measles (German)	<input type="checkbox"/>	<input type="checkbox"/>	Sulfa drugs	<input type="checkbox"/>	<input type="checkbox"/>
Mumps	<input type="checkbox"/>	<input type="checkbox"/>	Serum	<input type="checkbox"/>	<input type="checkbox"/>
Chicken pox	<input type="checkbox"/>	<input type="checkbox"/>	Salicylic acid, aspirin	<input type="checkbox"/>	<input type="checkbox"/>
Malaria	<input type="checkbox"/>	<input type="checkbox"/>	Hives	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Other (note below)	<input type="checkbox"/>	<input type="checkbox"/>
Gum / tooth trouble	<input type="checkbox"/>	<input type="checkbox"/>	<b>Surgery</b>	<input type="checkbox"/>	<input type="checkbox"/>
Sinusitis	<input type="checkbox"/>	<input type="checkbox"/>	Appendectomy	<input type="checkbox"/>	<input type="checkbox"/>
Eye problems	<input type="checkbox"/>	<input type="checkbox"/>	Tonsillectomy	<input type="checkbox"/>	<input type="checkbox"/>
Ear problems	<input type="checkbox"/>	<input type="checkbox"/>	Hernia Repair	<input type="checkbox"/>	<input type="checkbox"/>
Nose / throat problem	<input type="checkbox"/>	<input type="checkbox"/>	Other (note below)	<input type="checkbox"/>	<input type="checkbox"/>
Frequent colds	<input type="checkbox"/>	<input type="checkbox"/>			
Hay fever / Asthma	<input type="checkbox"/>	<input type="checkbox"/>			
Head injury with loss of consciousness	<input type="checkbox"/>	<input type="checkbox"/>	Insomnia	<input type="checkbox"/>	<input type="checkbox"/>
Frequent headaches	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety / depression	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	Worry / nervousness	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain / pressure	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Chronic cough	<input type="checkbox"/>	<input type="checkbox"/>			
Palpitation (heart)	<input type="checkbox"/>	<input type="checkbox"/>	Digestive problems	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>	Recurrent diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
Joint disease / injury	<input type="checkbox"/>	<input type="checkbox"/>	Recent weight gain / loss	<input type="checkbox"/>	<input type="checkbox"/>
Dislocation (knees)	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness, fainting	<input type="checkbox"/>	<input type="checkbox"/>
Dislocation (shoulder)	<input type="checkbox"/>	<input type="checkbox"/>	Weakness, paralysis	<input type="checkbox"/>	<input type="checkbox"/>
Back trouble	<input type="checkbox"/>	<input type="checkbox"/>	Veneral disease	<input type="checkbox"/>	<input type="checkbox"/>
Tumor, cancer, cryst.	<input type="checkbox"/>	<input type="checkbox"/>	Frequent urination	<input type="checkbox"/>	<input type="checkbox"/>
Gallblader trouble	<input type="checkbox"/>	<input type="checkbox"/>	<b>Women only</b>		
			Irregular periods	<input type="checkbox"/>	<input type="checkbox"/>
			Severe cramps	<input type="checkbox"/>	<input type="checkbox"/>
			Excessive flow	<input type="checkbox"/>	<input type="checkbox"/>

has your physical activity been restricted within the past five years?

Give reasons and length of restriction: \_\_\_\_\_

Which medication are you currently taking? \_\_\_\_\_

Have you received treatment or counseling for a nervous condition, personality disorder, or emotional problem in the last five years? Yes No

Have you been rejected for, or been discharged from, military service because of physical, emotional, or other reason? Yes No

Do you have any questions in regard to your health, family history or other matters which you would like to discuss with a member of the health service staff? Yes No

**Physical examination**

Eye sight: Right 20/ \_\_\_\_\_ Left 20/ \_\_\_\_\_  
 Height \_\_\_\_\_ Mts. Weight \_\_\_\_\_ Kg. Respiration rate \_\_\_\_\_ / min  
 Temp. \_\_\_\_\_ °C Health rate \_\_\_\_\_ / min Blood pressure \_\_\_\_\_ / \_\_\_\_\_ mm Hg.

**Health problems detected:**

Respiratory	<input type="checkbox"/>	<input type="checkbox"/>	Do you have any general comment?	<input type="checkbox"/>	<input type="checkbox"/>
Lung diseases	<input type="checkbox"/>	<input type="checkbox"/>			
Gastrointestinal	<input type="checkbox"/>	<input type="checkbox"/>	Do you have any recommendation related with the student's health care?	<input type="checkbox"/>	<input type="checkbox"/>
Genitourinary	<input type="checkbox"/>	<input type="checkbox"/>			
Muscle skeletal	<input type="checkbox"/>	<input type="checkbox"/>	Does he / she need any treatment because of physical or emotional problems?	<input type="checkbox"/>	<input type="checkbox"/>
Endocrine	<input type="checkbox"/>	<input type="checkbox"/>			
Neuropsychiatric	<input type="checkbox"/>	<input type="checkbox"/>			

\_\_\_\_\_  
Student's signature

\_\_\_\_\_  
Physician's signature

\_\_\_\_\_  
Registration number. S.S.A. and D. G. P.