

**Roger Estevez, MD P. C**

4020 Pecos McLeod Rd Las Vegas, Nevada 89121 Phone: (702) 570-6107

**PATIENT DEMOGRAPHICS / MEDICAL HISTORY FORM**

**(The following information is very important to your health. Please take the time to fully and completely fill out both sides. This is important information and we are counting on you.)**

**Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_ **Age:** \_\_\_\_  
**Gender:** F M

**Address:** \_\_\_\_\_

**Home Phone:** \_\_\_\_\_ **Cell Phone:** \_\_\_\_\_

**Emergency Contact:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_ **Phone #:** \_\_\_\_\_

**Race:** White \_\_\_ Black /African A \_\_\_ Asian \_\_\_\_\_ Filip \_\_\_ Latino \_\_\_ Other \_\_\_

**Reason for Visit:**  
\_\_\_\_\_

**Prescription and Non-Prescription Medications you are currently taking**

Or attach a list of all prescribed medication that you are taking now

<b>Medication Name</b>	<b>Dose</b>	<b>How often?</b>	<b>Start Date</b>
------------------------	-------------	-------------------	-------------------

**Indication**


**DL:**

**WORK P:**

**SOCIAL HISTORY**

Do you smoke? YES NO

Substance abuse? YES NO What Type?: \_\_\_\_\_

**Marital Status:**  Single  Married  Divorced  Widowed

Quantiferon positive::

Referral sent:

Xray ordered:

**Country and city where you were born?**

\_\_\_\_\_

Please let Us know

**How did you find out about us:**  Internet  Lawyer  Friend \_\_\_\_\_

Other: \_\_\_\_\_

**I'm Certify that the above information. I have provided to C.R.O.S.N. is accurate and current to the best of my Knowledge.**

