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.)

Nombre Completo: _____ **Fecha de nacimiento:** _____
Edad: ____ Genero: □F □M

Address: _____

Telefono de Casa:_____ **Cell Phone**:_____

Contacto de Emergencia:_____ Relacion:_____ **Phone #:**_____

Raza: Blanca ___ Negro /African A___ Asian_____ Filip ____ Latino ____

Rason de la Visita:

_____

Prescription and Non-Prescription Medications you are currently taking

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

Medicamentos que esta tomando Dose Cada q tiempo Comienzo Indication

DL: **Permiso de trabajo:**

HISTORIA Social

Fuma? ☐Si ☐NO Abuso de Sustancias? ☐Si ☐NO What Type?:_____

Estado Marital: ☐ Soltero ☐ Casado ☐ Divorciado ☐ Viudo

Quantiferon Positive: Referral sent:

Xray ordered:

Ciudad y Pais donde nacio: _____

Como supo usted de nosotros?: ☐ Internet ☐ Abogado ☐Amigo nombre:_____

☐ Otro: _____

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.