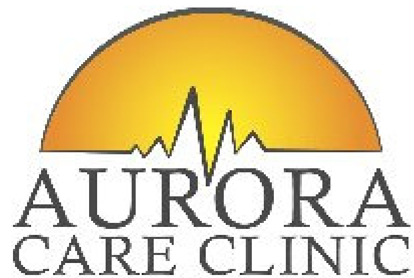
Please contact us at 714-285-9070 to see if you qualify for a current or upcoming study and to make an appointment.

You may print out and complete this form for your convenience and don't forget to bring it with you to your office visit.

(If you do not qualify for any current studies, we will keep your information in our database and contact you as soon as we have a study that you may qualify for.)



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Fax: 714-285-9069
Email: info@auroracareclinic.com

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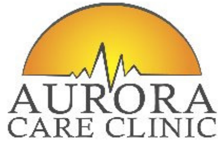
Santa Ana, California



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PATIENT REGISTRATION & MEDICAL HISTORY FORM

REGISTRO DEL PACIENTE Y FORMULARIO HISTROIAL MEDICO

DATE (FECHA): ______ /______ /_______

FULL NAME (NOMBRE COMPLETO):____
LAST NAME (APELLIDO) FIRST NAME (PRIMER NOMBRE) MIDDLE NAME (SEGUNDO NOMBRE)

ADDRESS (DIRECCION):____
STREET (CALLE)

____
CITY (CIUDAD) STATE (ESTADO) ZIP CODE (CODIGO POSTAL)

DATE OF BIRTH(FECHA DE NACIMIENTO):___________________________ AGE(EDAD):________ GENDER (GENERO):
☐ MALE (MASCULINO)
☐ FEMALE (FEMENINO)

SOCIAL SECURITY NUMBER _________________________ (LAST 4 DIGITS REQUIRED)
A# ALIEN NUMBER IF ANY (NUMERO DE REGISTRO DE EXTRANJERO):___________________________

PLACE OF BIRTH (LUGAR DE NACIMIENTO):______________________________________ _____________________
CITY/TOWN/VILLAGE (CIUDAD, PUEBLO, ALDEA) COUNTRY (PAIS)

HOME PHONE (TEL. PARTICULAR):_________________________ CELL (TELEFONO CELLULAR):________________________

EMERGENCY CONTACT INFORMATION:

IN CASE OF EMERGENCY, NOTIFY? ______________________________ PHONE (TEL.)________________
(EN CASO DE EMERGENCIA CONTACTAR)

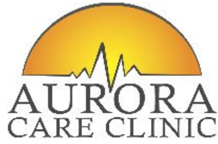
ADDRESS (DIRECCION):____
STREET (CALLE)

____
CITY (CIUDAD) STATE (ESTADO) ZIP CODE (CODIGO POSTAL)

PARENT OR LEGAL GUARDIAN (ONLY IF PATIENT IS UNDER 18 YEARS OF AGE):
(PADRE, MADRE O TUTOR LEGAL, UNICAMENTE SI EL PACIENTE ES MENOR DE 18 ANOS)

NAME (NOMBRE):____

PHONE NUMBER (TELEFONO):____________________________________ FAX (FAX):_____________________



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PRIMARY CARE DOCTOR (medico tratante):

NAME: (nombre):____

PHONE NUMBER (TELEFONO):____________________________FAX (FAX):____________________________

WHAT IS YOUR ETHNIC BACKGROUND (CUAL ES SU ORIGEN ETNICO)?:

☐ HISPANIC/LATINO (HISPANO/LATINO) ☐ AFRICAN AMERICAN (AFRICO-AMERICANO) ☐ ASIAN (ASIATICO) ☐ CAUCASIAN (CAUCASICO) ☐ NATIVE AMERICAN (NATIVO AMERICANO)
☐ OTHER (OTRO)

CURRENT MEDICATION DOSE, HOW LONG ON MEDICATION, AND REASON:
(DOSIS ACTUAL DE MEDICAMENTOS, CUANTO TIEMPO EN LA MEDICACION, Y LA RAZON):

____

____

____

____

____

DRUG / FOOD ALLERGIES (ESUSTED ALERGICO A ALGUN MEDICAMENTO O COMIDA)?:

____

____

DO YOU TAKE ASPRIN (TOMA ASPIRINA):? ☐ NO ☐ YES

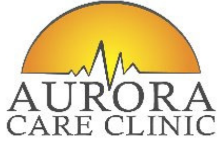
IF YES, MOST RECENT DOSE (SI ES ASI, LA DOSIS MAS RECIENTE)?:____________________________________

ARE YOU PREGNANT (ESTA EMBARAZADA)?: ☐ NO ☐ YES ☐ **N/A, MALE (NO APLICA)**

DATE OF LAST MENSTRUAL PERIOD (FECHADE SU ULTIMA MENSTRUACION):? ______ / ______ / ________

DO YOU DRINK ALCOHOL?: ☐ NO ☐ YES **IF SO, HOW MUCH AND HOW OFTEN?**_________________
(TOMA USTED ALCOHOL) (SI ES ASI QUE TANTO, U QUE TAN FRECUENTE)

BEER (CERVEZA):? ☐NO ☐YES **WINE** (VINO):? ☐ NO ☐ YES **HARD LIQUOR**(LICOR FUERTE):? ☐ NO ☐ YES



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DO YOU SMOKE:? ☐ NO ☐ YES IF SO, HOW MANY PACKS/DAY:?_________________
(FUMA USTED) (SI ES ASI CUANTOS PAQUETES/CIGATTILLOS AL DIA)

DID YOU SMOKE IN THE PAST?☐NO ☐YES FOR HOW LONG?:_______ WHEN DID YOU QUIT?:____
(HA FUMADO ANTERIORMENTE) (POR CUANTO TIEMPO) (CUANDO PARO DE FUMAR)

MEDICAL HISTORY (HISTORIAL MEDICO):
PLEASE INCLUDE ALL MEDICAL PROBLEMS THAT YOU CURRENTLY HAVE OR HAVE HAD IN THE PAST, ALSO PLEASE INCLUDE DATES (POR FAVOR INCLUYA TODOS LOS PROBLEMAS MEDICOS QUE ACTUALMENTE TIENEN O HAN TENIDO EN EL PASADO, TAMBIEN POR FAVOR INCLUYA FECHAS):
____
____
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____
____
____

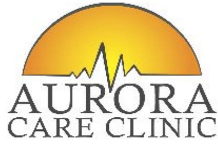
SURGICAL HISTORY (HISTORIAL DE CIRUGIAS)
OPERATION (OPERACION): REASON/HOSPITAL (RAZON/HOSPITAL): DATE (FECHA):
____
____
____
____
____
____

FAMILY HISTORY (IF ALIVE, AGE & HEALTH; IF DECEASED, AGE AT DEATH & CAUSE):
(HISTORIA FAMILIAR: SI VIVE, EDED Y SALUD; SI FALLECIO, A QUE EDAD, Y CAUSA)

MOTHER NAME:____

FATHER NAME:____

ANY BLOOD RELATIVES WITH A HISTORY OF (DE PARIENTES CONSANGUINEOS, CON UNA HISTORIA DE):
CANCER, STONES, PROSTATE, BLADDER, KIDNEY, OR OTHER UROLOGIC DISORDERS ☐ NO ☐ YES



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DO YOU CURRENTLY HAVE OR HAVE YOU EVER HAD (ALGUNA VEZ TUVISTE O HAS TENIDO)**:**

BLEEDING PROBLEMS (PROBLEMAS DE SANGRADO) .... ☐ NO ☐ YES
STEROID/PREDNISONE (ESTEROIDES/CORTISONA) .... ☐ NO ☐ YES
THYROID PROBLEM (PROBLEMAS TIROIDES) .... ☐ NO ☐ YES
PARKINSON'S DISEASE (ENFERMEDAD DE PARKINSON) .... ☐ NO ☐ YES
STOMACH ULCERS (ULCERAS EN EL ESTOMA) .... ☐ NO ☐ YES
RHEUMATIC FEVER (FIEBRE REUMATICA) .... ☐ NO ☐ YES
EMPHYSEMA/BRONCHITIS (ENFISEMA/BRONQUITIS) .... ☐ NO ☐ YES
BLOOD TRANSFUSION (TRANSFUSIONES DE SANGRE) .... ☐ NO ☐ YES
HEART MURMUR (SOPLOS CARDIACOS) .... ☐ NO ☐ YES
HIGH BLOOD PRESSURE (ALTA PRESION) .... ☐ NO ☐ YES
HEART ATTACK (ATAQUES EN EL CORAZON) .... ☐ NO ☐ YES
CHEST PAIN (DOLOR EN EL PECHO) .... ☐ NO ☐ YES
HEART FAILURE (FALLA CARDIACA) .... ☐ NO ☐ YES
ANKLE SWELLING (EDEMA EN SUS TOBILLOS) .... ☐ NO ☐ YES
ARTIFICIAL JOINT (ARTICULACIONES ARTIFICIALES) .... ☐ NO ☐ YES
PHLEBITIS (FLEVITIS) .... ☐ NO ☐ YES
ANEMIA .... ☐ NO ☐ YES
DIABETES .... ☐ NO ☐ YES
CONSTIPATION (ESTRENIMIENTO) .... ☐ NO ☐ YES
HIATAL HERNIA (HERNIA HIATAL) .... ☐ NO ☐ YES
HEPATITIS .... ☐ NO ☐ YES
OSTEOARTHRITIS .... ☐ NO ☐ YES
RHEUMATOID ARTHRITIS .... ☐ NO ☐ YES
CANCER .... ☐ NO ☐ YES
TB (TUBERCULOSIS) .... ☐ NO ☐ YES
ASTHMA (ASMA) .... ☐ NO ☐ YES
COPD .... ☐ NO ☐ YES
STROKES (EMBOLIAS) .... ☐ NO ☐ YES
PNEUMONIA (NEUMONIA) .... ☐ NO ☐ YES
EPILEPSY / SEIZURES (CONVULSIONES) .... ☐ NO ☐ YES
MUMPS .... ☐ NO ☐ YES
GLAUCOMA .... ☐ NO ☐ YES
WEIGHT LOSS .... ☐ NO ☐ YES
ARE YOU TRYING TO LOSE WEIGHT? .... ☐ NO ☐ YES
OTHER____