

## Historial Medico

Medico: \_\_\_\_\_ Telefono: \_\_\_\_\_

Direccion de oficina: \_\_\_\_\_

Esta usted: actual enfermo/a: **Si No** Bajo el cuidado de un medico: **Si No**

Esta tomando medicamento: **Si No** Tiene Alergias a un medicamento: **Si No**

Si tiene alergias lista por favor: \_\_\_\_\_

Alergica a algo mas?: **Si No** si tiene, porfavor explique: \_\_\_\_\_

A tenido : (circle all that apply)

Anemia	Chronic Illness	Hospitalization	Heart Disorder
Asthma	Convulsions	Hyperactivity	Heart Trouble
AIDS/HIV	Diabetes	Illness in Infancy	Hepatitis
Bleeding Problems	Emotional Problems	Learning Difficulty	Mental Disorder
Birth Defects	Epilepsy/Seizures	Liver Disease	Milk Allergy
Rheumatic Fever	Speech Impediment	Surgery	Tuberculosis
Tumors/Cancer	Sickle Cell Anemia	Osteoporosis	Arthritis

Please explain any other problems: \_\_\_\_\_

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## Historial Dental

Dentista: \_\_\_\_\_ Fue refi: Yes No

Please list what concerns you have about the health and/or appearance of your teeth:

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Any pervious dental care: Yes No What for: \_\_\_\_\_

Is there now or has there ever been any of the following: (circle all that apply)

Pain of the TMJ	Oral Habits	Cavities	Toothache	Gum Disease
Extracted Teeth	Injured Teeth	Braces	Unfavorable Experiences	
Thumb Sucking	Lip Biting/ Sucking			

Explain any issues: \_\_\_\_\_

Names and ages of other children in the family: \_\_\_\_\_

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