**Historia Clínica Odontológica**

Ciudad Historia Clínica

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Fecha

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**DATOS GENERALES**

Apellidos Nombres Edad Sexo Ocupación

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Dirección Teléfono Celular E-mail

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**DATOS DEL REPRESENTANTE , ACUDENTE Ó PERSONA A LLAMAR EN CASO DE EMERGENCIA**

Apellidos Nombres Edad Ocupación Parentesco

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Dirección Teléfono Celular

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**Motivo de Consulta**

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**Anamnesis** Si No Si No

* Tratamiento Médico \_\_\_ \_\_\_ Traumas o Accidentes \_\_\_ \_\_\_
* Toma medicamentos \_\_\_ \_\_\_ Enfermedad Cardiaca \_\_\_ \_\_\_
* Cirugía \_\_\_ \_\_\_ Embarazo \_\_\_ \_\_\_
* Alergia anestesia \_\_\_ \_\_\_ Asma \_\_\_ \_\_\_
* Hemorragia \_\_\_ \_\_\_ Consume Alcohol \_\_\_ \_\_\_
* Diabetes \_\_\_ \_\_\_ Consume cigarrillo \_\_\_ \_\_\_
* Enfermedad respiratoria \_\_\_ \_\_\_ Enf. Transmisión Sexual \_\_\_ \_\_\_
* Hipertensión arterial \_\_\_ \_\_\_ Otra \_\_\_ \_\_\_

**Observaciones:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Historia Dental**

Ultima visita al odontólogo \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Frecuencia cepillado\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Seda dental, enjuague bucal, palillos\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cambio de Cepillo \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Examen Intraoral**

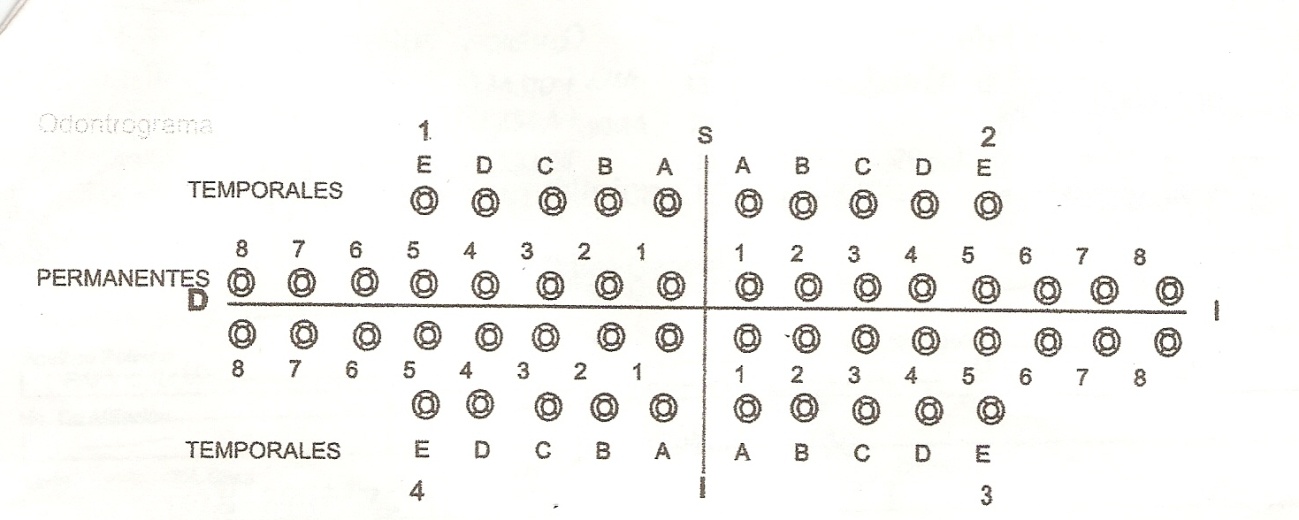
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| N A N A Si No Si No  Paladar \_\_ \_\_ Oclusión \_\_ \_\_ Cambios color \_\_ \_\_ P. blanda \_\_ \_\_  Amígdalas \_\_ \_\_ Rebordes alveolares \_\_ \_\_ Anom. Forma \_\_ \_\_ P. calcificada \_\_ \_\_  Carrillos \_\_ \_\_ Lengua \_\_ \_\_ Anom. Tamaño \_\_ \_\_ Enf. Perio \_\_ \_\_  Labios \_\_ \_\_ Piso de boca \_\_ \_\_ Patología pulpar \_\_ \_\_ Gingivitis \_\_ \_\_  Atm \_\_ \_\_ Encías \_\_ \_\_ Fracturas \_\_ \_\_ Bolsa per \_\_ \_\_ |

Porcentaje placa \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dx periodontal \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Observaciones \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Odontograma**



**Diagnostico**

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**Plan de tratamiento**

\_IDEAL:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ALTERNATIVO\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EVOLUCIÓN**

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| Fecha | Diente | Tratamiento realizado | Firma |
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