**HISTORIA CLÍNICA ORTODONCIA**

Ciudad Historia Clínica Nº

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Fecha

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1) **Datos Personales:**

Apellidos Nombres Edad Ocupación Teléfono

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Dirección Doc. Identidad Nombre familiar o responsable

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**2) Motivo de Consulta**

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**3) Anamnesis:**

* Tratamiento Médico \_\_\_  **\*** Enfermedades Respiratorias \_\_\_
* Toma medicamento \_\_\_ **\*** Enfermedades Cardiacas \_\_\_
* Cirugía \_\_\_  **\*** Enfermedades Endocrinas \_\_\_
* Diabetes \_\_\_  **\*** Enfermedades Trans. Sexual \_\_\_
* Hipertensión Arterial \_\_\_ **\*** Embarazo \_\_\_\_\_\_\_\_\_\_
* Alergias \_\_\_ **\*** Trauma o Accidente: \_\_\_\_
* Otras \_\_\_ \* Respiración \_\_\_\_\_\_
* Masticación: Unilateral\_\_\_\_\_\_Bilateral \_\_\_\_\_\_
* Higiene oral: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**4) Examen Extraoral**

* Perfil: \_\_\_\_\_\_\_\_\_
* Análisis de tercios: Sup\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Med\_\_\_\_\_\_\_\_\_\_\_\_ Inf\_\_\_\_\_\_\_\_\_\_\_\_\_
* Labio superior: Proquelia:\_\_\_\_\_ Retroquelia\_\_\_ Normal\_\_\_\_\_
* Labio inferior: Proquelia:\_\_\_\_\_\_ Retroquelia:\_\_\_\_ Normal\_\_\_\_
* Arco de sonrisa: Consonante:\_\_\_\_\_\_ No consonante:\_\_\_\_\_
* Tipo de sonrisa: Normal\_\_\_\_ Gingival\_\_\_\_ Senil o baja:\_\_\_\_\_
* Línea media facial: Coincidente\_\_\_ No coincidente\_\_\_\_\_\_
* Análisis frontal\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \* Selle labial\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Maxilar\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \* Mandíbula\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**5) Examen Intraoral (Esto va igual en un modulo aparte)**

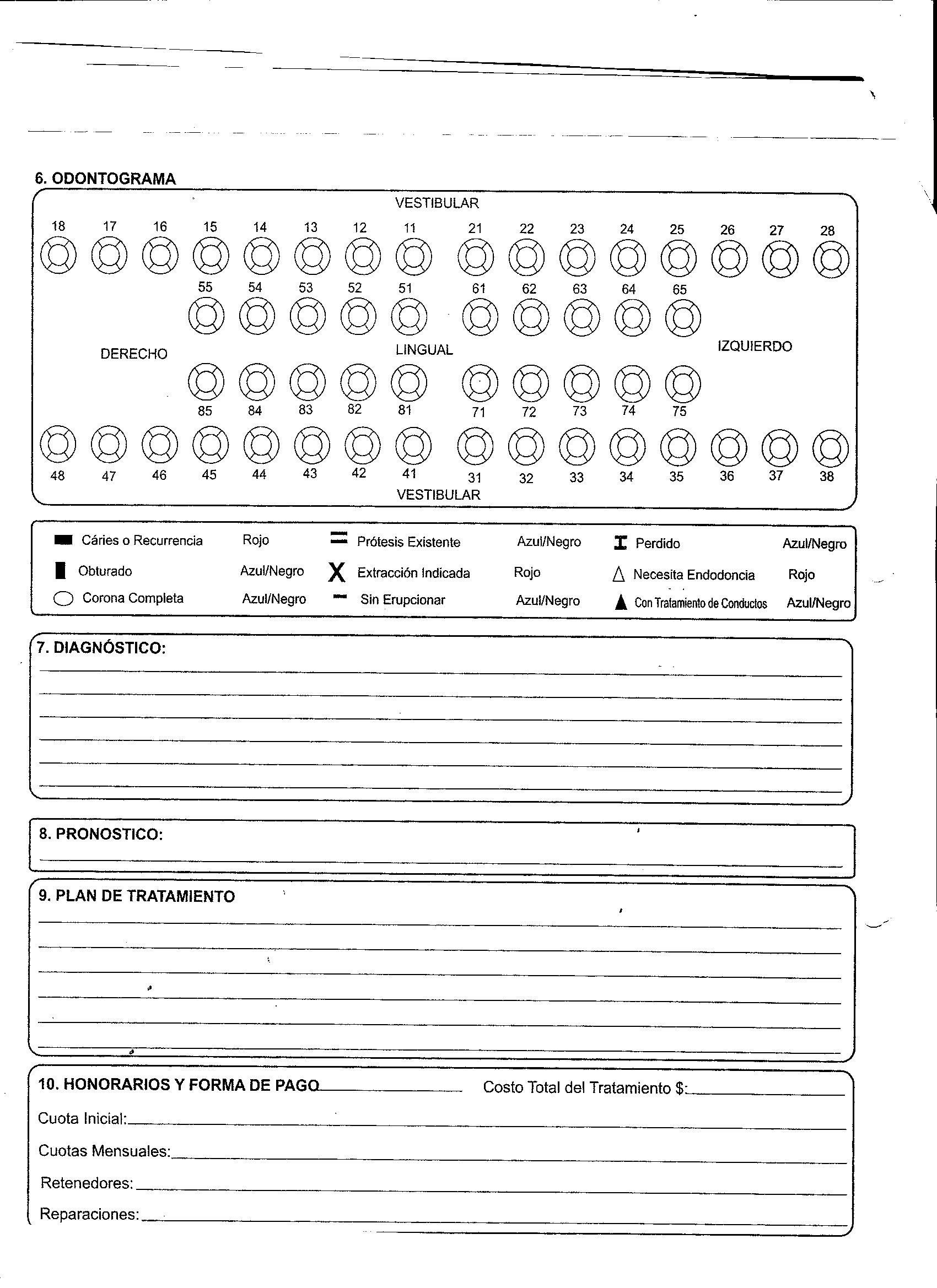
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| --- | --- | --- |
| **Oclusión de frente** | **Oclusión Derecha** | **Oclusión Izquierda** |
| Línea Media: | Clase Canina: | Clase Canina: |
| Plano oclusal: | Clase Molar: | Clase Molar: |
| Malposición: | Malposición: | Malposición: |
| Overjet: | Overjet: | Overjet: |
| Overbite: | Overbite: | Overbite: |
| Sonrisa: | Curva de Spee: | Curva de Spee: |
| Otros: | Otros: | Otros: |

**6) Análisis Radiográfico( pero agregar modulo de Hallazgo)**

Radiografía Hallazgos

|  |  |
| --- | --- |
| Panorámica |  |
| Cefálica |  |
| Periapical |  |

**6) Odontograma (No va odontograma, colocar una selección para un plan unico de tratamiento)**



**7) Diagnostico (Esto va en un modulo aparte)**

Funcional:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Facial:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Esqueletico:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dental: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**8) Plan de tratamiento**

Ideal\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Real\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**9) Honorarios y Forma de pago**

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| Cuota Inicial | Controles | Reparación | Aparatología extra | Retenedores |
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**10) Evolución**

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| Fecha | Tratamiento Realizado | | | | Abono | Debe | | Firma |
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