GOOD NEWS CLINICS
DENTAL HEALTH HISTORY

NAME/NOMBRE: _____DATE/FECHA: _____

Name of the last dentist you saw?/Nombre del ultimo dentista que vio _____.

	YES/SI	NO
1. Do you have pain in any area of your mouth? -Tiene dolor en algun lugar de su boca?	_____	_____
2. Are you in good health?/Tiene Buena salud?	_____	_____
3. Are you under the care of a physician? - Esta bajo el cuidado de un medico?	_____	_____
4. Have you been hospitalized or have had a serious illness - within the past five years?/ Ha estado hospitalizado o ha tenido una enfermedad seria en los ultimos cinco años?	_____	_____
5. Do you smoke? Fuma?	_____	_____

6. Are you taking any medications? If yes, please list them. /Esta tomando algun medicamento? Si es si,cuales?

7. Have you ever taken or are you taking any of these medications?/- Usted esta tomando o toma alguno de los siguientes medicamentos?
   (Please circle if YES/circule si es si)

ACTONEL / AREDIA / BONEFOS / BONIVA / DIDRONEL / FOSAMAX / OSTAC / SKELID / ZOMENTA

8. Are you allergic or have you reacted adversely to any of the following medications Es usted alergico o ha tenida una reaccion seria con alguno de los siguientes medicamentos?
   (Please circle if YES/circule si es si)

ASPIRIN/ASPIRINA	**PENICILLIN/PENICILINA**	**LATEX/HULE**
SULFUR/SULFA	**CODEINE/CODEINA**	**LOCAL ANESTHETIC/ANESTESIA LOCAL**

9. Have you ever had?/ Usted ha tenido? **(Please circle if YES/circule si es si)**

Heart attack/ Ataque al Corazon	Heart trouble/Problemas del Corazon	Stroke/ Derrame Cerebral
High blood pressure/Alta Presion	Rheumatic Fever/Fiebre Reumatica	Convulsions/Convulsiones
Diabetes/Diabetes	Glaucoma/Glaucoma	Ulcers/Ulceras
Heatitis/Hepatitis	Venereal Diseases/Enfermedad Venerea	Blood transfusion/Transfusión de Sangre
Tumor or Growth/Tumor o Crecimiento	Arthritis/Arthritis	Cancer, Chemotherapy or Radiation
Kidney Disease/Enfermedad de los Riñones	Epilepsy/Epilepsia	Tuberculosis/Tuberculosis
Anemia/Anemia	HIV or AIDS/ HIV sida	

FOR WOMEN ONLY	YES/SI	NO
10. Are you pregnant? /Esta embarazada? What month/Que Mes _____	_____	_____
11. Are you taking birth control pills/Esta tomando anticonceptivos?	_____	_____