LAKESHORE community health care

Antecedentes Médicos

Nombre:_____ **Fecha de Nacimiento:**_____ **Fecha de Hoy:**_____

Medicamentos

List **ALL** medications and dosages:
Include birth control, herbals, vitamins and any over the counter medications.

Have you ever taken Fosamax, Actonel, Boniva or similar medication? ☐ **YES** ☐ **NO**

Allergies

Penicillin/Amoxicillin:	☐ **SÍ**	☐ **NO**
Erythromycin:	☐ **SÍ**	☐ **NO**
Sulfa:	☐ **SÍ**	☐ **NO**
Local Anesthetic:	☐ **SÍ**	☐ **NO**
Codeine:	☐ **SÍ**	☐ **NO**
Aspirin/Ibuprofen:	☐ **SÍ**	☐ **NO**
Latex:	☐ **SÍ**	☐ **NO**

Other medication:

Food Allergy:

Environment Allergy:

Family Health History

Do **ANY** of your family members suffer from any of the following? **(INDENTIFY WHO)**

Hypertension:_____
Heart Disease:_____
Cancer (with type):

Diabetes:_____
Thyroid Problems:_____
Anxiety:_____
Depression:_____
Bipolar illness:_____
Schizophrenia:_____
Substance Use:_____

Antecedentes Médicos

Asma:	☐ **SÍ**	☐ **NO**
Chronic Cough/COPD:	☐ **SÍ**	☐ **NO**
Tuberculosis:	☐ **SÍ**	☐ **NO**
Liver Disease:	☐ **SÍ**	☐ **NO**
Hepatitis:	☐ **SÍ**	☐ **NO**
Seizures/Epilepsy:	☐ **SÍ**	☐ **NO**
Headache/Migraine:	☐ **SÍ**	☐ **NO**
History of Fainting:	☐ **SÍ**	☐ **NO**
Kidney Disease:	☐ **SÍ**	☐ **NO**
Diabetes:	☐ **SÍ**	☐ **NO**
High Blood Pressure:	☐ **SÍ**	☐ **NO**
Heart Disease/Valve disease	☐ **YES**	☐ **NO**
Pacemaker:	☐ **SÍ**	☐ **NO**
High Cholesterol:	☐ **SÍ**	☐ **NO**
Stroke:	☐ **SÍ**	☐ **NO**
Cancer:	☐ **SÍ**	☐ **NO**
Radiation or Chemotherapy:	☐ **YES**	☐ **NO**
Depression/Anxiety:	☐ **YES**	☐ **NO**
Bipolar:	☐ **YES**	☐ **NO**
Schizophrenia:	☐ **YES**	☐ **NO**
HIV/AIDS:	☐ **YES**	☐ **NO**
Bleeding or Blood disorders	☐ **YES**	☐ **NO**
History of Blood Clot:	☐ **YES**	☐ **NO**
Blood Transfusion:	☐ **YES**	☐ **NO**
Thyroid Disease:	☐ **YES**	☐ **NO**
History of Eye Surgeries:	☐ **YES**	☐ **NO**
Glaucoma:	☐ **YES**	☐ **NO**
Hearing Loss or Impairment:	☐ **YES**	☐ **NO**
Back or Joint pain:	☐ **YES**	☐ **NO**
Artificial Joints:	☐ **YES**	☐ **NO**
Osteoporosis/Bone Loss:	☐ **YES**	☐ **NO**
Drug or Alcohol Dependence:	☐ **YES**	☐ **NO**

Sexually Transmitted Diseases: (PLEASE LIST)

Other:

Have you had any hospitalizations or surgeries: ☐ **YES** ☐ **NO**

Otros Antecedentes Médicos

¿Es usted sexualmente activo? ☐ **SÍ** ☐ **NO**
¿Está embarazada/amamantando? ☐ **SÍ** ☐ **NO**
Número de hijos:_____
Número de embarazos:_____

Dental History

Última visita al odontólogo:_____
¿Sufre de ansiedad por visitas odontológicas? ☐ **SÍ** ☐ **NO**
Preocupaciones odontológicas actuales:
En caso AFIRMATIVO, ¿cuáles? ☐ **SÍ** ☐ **NO**

¿Sufre actualmente de DOLOR? ☐ **SÍ** ☐ **NO**
Dolor o entumecimiento en ☐ **CARA** ☐ **CUELLO** ☐ **BOCA**
¿Tiene algún diente FLOJO? ☐ **SÍ** ☐ **NO**
¿SANGRAN sus encías? ☐ **SÍ** ☐ **NO**
¿APRIETA o RECHINA los dientes? ☐ **SÍ** ☐ **NO**
¿Utiliza PRÓTESIS DENTALES? ☐ **SÍ** ☐ **NO**
Si responde SÍ, ☐ Parciales ☐ Completas

Have you had BRACES:	☐ **YES**	☐ **NO**
Do you SNORE:	☐ **YES**	☐ **NO**
Sore/Lesions lasting > 2 wks:	☐ **YES**	☐ **NO**
Have Chronic Hoarseness:	☐ **YES**	☐ **NO**

How often do you BRUSH:_____
How often do you FLOSS:_____
Do you regularly drink:

Soda	___ x Day	☐ NO
Juice	___ x Day	☐ NO
Energy Drinks	___ x Day	☐ NO

Social History

Alcohol use: ☐ **CURRENT** ☐ **PAST** ☐ **NEVER**

For Women: In the past year, have you had more than 3 drinks of any kind of alcohol in one day or more than 7 in a week? ☐ **YES** ☐ **NO**

For Men: In the past year, have you had more than 4 drinks of any kind of alcohol in one day or more than 14 in a week? ☐ **YES** ☐ **NO**

In the past 28 days, have you had any of the following drugs? (**SELECT ALL THAT APPLY**)

☐ Marijuana ☐ Inhalants
☐ Sedatives ☐ Hallucinogens
☐ Cocaine ☐ Opioids
☐ Amphetamines/Stimulants
☐ IV drug use: _____

I have answered all questions to the best of my knowledge.

Patient/Guardian Signature:_____ **Date:**_____