NORTH EAST MEDICAL SERVICES
東 北 醫 療 中 心
a california health+ center

NEMS ID:

NAME:

DOB:

DENTAL HISTORY
牙科病歷

Do you have or have you had any problem(s) with dental treatment in the past? Yes 是 ☐ No 否 ☐
以前是否有任何牙齒治療的問題?

Do you need pre-medicated with antibiotic before dental appointment in the past? ☐ ☐
以前是否曾在見牙醫之前要服用抗生素?

Has there been any change in your general health in the last two years? ☐ ☐
過去兩年內您的總體健康狀況有否任何變化?

Have you taken any medication for osteoporosis? If yes, for how long?_____ ☐ ☐
您是否曾服用任何骨質疏鬆症的藥物? 如果有，有多久?

Are you now under the care of a physician? If yes, physician's name: ☐ ☐
您目前有沒有主診醫生? 如果有，醫生姓名: _____

Any serious illness, operations, or hospitalizations in the last 5 years? If yes, please describe:
過去五年內是否患有嚴重的疾病、動手術、或住醫院? 如果有，請說明

_____

Approximate date of last physical exam? 最後體檢的大概日期?
_____/_____/_____

Females: are you pregnant? If yes, how many months? ☐ ☐
女性: 現在是否懷孕? 如果是，有幾多個月? _____

Are you taking any of the following 您是否在服用以下任何一種或幾種藥物:

	Yes 是	No 否		Yes 是	No 否
Anticoagulants (blood thinners) 抗凝劑 (血液稀釋劑)	☐	☐	Heart drugs 心臟藥物	☐	☐
Blood pressure medication 治療高血壓藥物	☐	☐	Insulin 胰島素	☐	☐
Cortisone (steroids) 可體松 (類固醇)	☐	☐	Antibiotics 抗生	☐	☐

Other medications 其它药物 _____

Have you had a bad reaction to the following: 您有否對以下任何一種藥物／材料產生過不良反應:

	Yes 是	No 否		Yes 是	No 否
Local anesthetics (novocaine, lidocaine) 局部麻醉劑 (奴佛卡因、利多卡因)	☐	☐	Aspirin or codeine 阿司匹林或可待因	☐	☐
Penicillin or other antibiotics 盤尼西林 (青黴素) 或其它抗生素	☐	☐	Latex allergy 乳膠過敏	☐	☐

Other medications 其它药物 _____

Do you now have, or have you had any of the following? 您現在或以前有否下述症狀?

	Yes 是	No 否		Yes 是	No 否		Yes 是	No 否
Stomach ulcers 胃潰瘍	☐	☐	Hypertension 高血壓	☐	☐	High cholesterol 膽固醇	☐	☐
Chest pain/angina 胸痛／心絞痛	☐	☐	Kidney disease 腎病	☐	☐	Recreational drugs 娛樂性藥物	☐	☐
HIV/AIDS 愛滋病	☐	☐	Asthma 哮喘	☐	☐	Stroke 中風	☐	☐
Previous cancer 曾患過癌症	☐	☐	Breathing issues 呼吸問題	☐	☐	Psychiatric problems 心理問題	☐	☐

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	Yes 是	No 否		Yes 是	No 否
Abnormal bleeding after surgery 手術後異常出血	☐	☐	Chronic sinus problems 慢性鼻竇問題	☐	☐
Developmental/intellectual disability 發育/智力障礙	☐	☐	Hemophilia or anemia 血友病或貧血	☐	☐
Diabetes or high blood sugar 糖尿病或高血糖病	☐	☐	Artificial joint/implant 人造關節／移植	☐	☐
Hepatitis, jaundice, liver disease 肝炎、黃疸病或肝病	☐	☐	Thyroid disease or goiter 甲狀腺病或甲狀腺腫	☐	☐
Problems with opening mouth wide 難於張開大口	☐	☐	Use tobacco products 吸食煙草製品	☐	☐
Radiation treatment for tumor 腫瘤放射治療	☐	☐	Congenital heart disease 先天性心臟病	☐	☐
Rheumatic fever or heart murmur 風濕熱或心臟雜音	☐	☐	Seizures, epilepsy, fainting 發羊吊、癲癇病、昏厥	☐	☐
Tuberculosis, emphysema, bronchitis 肺結核、肺氣腫或支氣管炎	☐	☐	Heart attack/heart surgery 心臟病發作／心臟手術	☐	☐
Frequent severe headaches 經常性劇烈頭痛	☐	☐			

Other health problems or conditions
其它健康問題或狀況: _____

I have read and answered the above questions to the best of my knowledge. I understand this information is necessary to provide me with dental care in a safe and efficient manner. I will notify this clinic of any future changes in the health or medications taken by me.

本人已經閱讀並盡我所知回答了以上問題。本人了解這些信息對於以安全有效的方式為我提供牙科護理是必要的。如果日後本人的健康狀況或服用的藥物有任何變化，我會通知此診所。

Signature of Patient or Legal Representative*
會員或合法代表簽名

Date
日期

Name of Legal Representative
合法代表姓名

Relationship of Legal Representative
合法代表與會員的關係

Signature of Witness (Required if patient is unable to sign)
見證人簽名（會員無法自行簽字時此項必填）

Date
日期