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

NEMS MRN:

NAME:

DOB:

# DENTAL HISTORY FOR PEDIATRIC PATIENTS
# 兒童及青少年牙科病歷

If you are a parent or guardian, please answer the following questions on behalf of the child. If you are a child filling out this form yourself, please answer the questions on your own behalf.
如果您是父母或監護人，請代表您的孩子回答以下問題。如果您是孩子本人，請自行回答以下問題。

| | | |
|---|---|---|
| 1. Do you have/does the child have or have had<br>您/您的孩子現在或以前是否有過: | | |
| a. Any particular concerns about his/her/your mouth / teeth / overall oral health?<br>任何口腔／牙齒／整體口腔保健的問題?<br>If YES, please describe<br>如果有，請說明 _____ | ☐ Yes 是 | ☐ No 否 |
| b. Any problem(s) with dental treatment in the past?<br>以前是否有任何牙齒治療的問題? | ☐ Yes 是 | ☐ No 否 |
| c. Any facial or head injuries?<br>面部或頭部有沒有任何的受傷? | ☐ Yes 是 | ☐ No 否 |
| d. Special dental treatment(s) such as braces, jaw surgery, hospital dentistry, etc.?<br>有沒有任何特殊的牙科治療，如：牙齒矯正、顎部手術或要在醫院接受牙科治療? | ☐ Yes 是 | ☐ No 否 |
| e. Pre-medicated with antibiotic before dental appointment in the past?<br>以前是否曾在見牙醫之前要服用抗生素? | ☐ Yes 是 | ☐ No 否 |
| f. Been shown how to floss or brush?<br>有沒有人教過您/您的孩子如何使用牙線或刷牙? | ☐ Yes 是 | ☐ No 否 |
| 2. Does the child/do you brush or floss?<br>您/您的孩子刷牙或使用牙線嗎?<br>If YES, how often?<br>如果有，多久一次? _____ | ☐ Yes 是 | ☐ No 否 |
| 3. Has there been any change in the child's or your general health in the last two years?<br>過去兩年內您/您的孩子的總體健康狀況有否任何變化? | ☐ Yes 是 | ☐ No 否 |
| 4. Approximate date of last physical exam?<br>最近體檢的大概日期? | ____/____/____ | |

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| | | |
|---|---|---|
| 5. Is the child/are you now under the care of a physician?<br>您/您的孩子目前有沒有主診醫生?<br>If YES, Physician's name:<br>如果有，醫生姓名: _____ | ☐ Yes 是 | ☐ No 否 |
| 6. Any serious illness, operations, or hospitalizations in the last 5 years?<br>過去五年內是否患有嚴重的疾病、動手術、或住醫院?<br>If YES, please describe<br>如果有，請說明 _____ | ☐ Yes 是 | ☐ No 否 |
| 7. Is the child/are you taking any medication(s)?<br>您/您的孩子現在是否有服用任何藥物?<br>If YES, please describe<br>如果有，請說明 _____ | ☐ Yes 是 | ☐ No 否 |
| 8. Is the child/are you allergic or has he/she/you reacted adversely to any medication or food?<br>您或您的孩子是否有過敏，或曾對藥物或食物產生過不良反應?<br>If YES, please describe<br>如果有，請說明 _____ | ☐ Yes 是 | ☐ No 否 |
| 9. **PLEASE ANSWER THE FOLLOWING QUESTIONS**<br>**請回答以下問題:** | | |
| a. Does the child/do you use tobacco products?<br>您/您的孩子是否吸食煙草製品? | ☐ Yes 是 | ☐ No 否 |
| b. Females: Is the child/are you pregnant?<br>女性:您/您的孩子現在是否懷孕? | ☐ Yes 是 | ☐ No 否 |
| 10. Other Health Problems or Conditions<br>其它健康問題或狀況:<br>_____<br>_____ | | |

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**I HAVE READ AND ANSWERED THE ABOVE QUESTIONS TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THIS INFORMATION IS NECESSARY TO PROVIDE THE CHILD 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 THE CHILD.**
**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孩子提供牙科護理是必要的。如果日後孩子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