

# Case 3

## 高醫牙科門診記錄 (Dental Chart)

病歷號碼 Chart No.: XXXXXXXX Insurance Yes 健保 No 一般  
 姓名 Name: XXX 性別 Sex: 男 出生日期 Birthday: 44 年 6 月 19 日  
 籍貫 Native: 屏東 婚姻狀況:  已婚  未婚 初診日期 First visit: XXXXXX  
 Marital status yes no  
 職業 Occupation: 工 電話 Tel: XXXXXX 血型 Blood type: B  
 地址 Address: 高雄市左營區左營大路292-29-1樓

**Medical Alert**  
 抽煙 有(yes), 無(no) 多久 \_\_\_\_\_  
 Smoking 每日數量 \_\_\_\_\_ 包, 目前有, 無抽  
 喝酒 有(yes), 無(no) 多久 \_\_\_\_\_  
 Alcohol 每日數量 \_\_\_\_\_ 瓶, 目前有, 無喝  
 吃檳榔 有(yes), 無(no) 多久 \_\_\_\_\_  
 Betel quid 每日數量 \_\_\_\_\_ 顆, 目前有, 無吃  
 其他習慣或嗜好 (Other hobbies?) \_\_\_\_\_

健康問題: 請仔細據實回答下列問題, 請於空格處鈎選  Yes No Unknown  
 你有下列疾病嗎? (Do you have the following diseases?) 有 無 不詳

Health Question	Yes (有)	No (無)	Unknown (不詳)
1. 肝炎或肝病 (hepatitis, liver disease) -----	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. 腫瘤或癌症 (neoplasm, cancer) -----	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. 心臟病, 心律不整 (heart disease, arrhythmia) -----	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. 高血壓 (hypertension, high blood pressure) -----	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. 甲狀腺疾病 (thyroid disease) -----	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. 肺結核 (tuberculosis) -----	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. 腎臟病 (renal disease) -----	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8. 糖尿病 (diabetes mellitus) -----	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
9. 血液疾病 (blood disorder) -----	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
10. 性病 (sexual transmitted disease) -----	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
11. 懷孕 (pregnancy currently) -----	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
12. 您過去有沒有住過院? Have you been hospitalized? ----- 為什麼住院? (Why?) <u>骨傷</u>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. 您曾有過過敏的經驗嗎? Do you have drug allergy history? ----- 何種藥物或其他過敏物? (Name of drug) <u>Acetaminophen, cephalixin, soma, paral</u>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. 您目前正在服用藥物嗎? (包含情緒及精神方面的藥物) ----- (Do you have medication currently? Include psychiatric drug?) 為什麼服藥 (Why?) _____ 服用多久了 (How long?) _____ 藥名 (Drug name?) _____	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
15. 您曾經接受過放射線治療嗎? (不含一般檢查用的 X 光) ----- (Do you have received radiotherapy?) 治療部位 (Region?) _____ 治療多久 (How long?) _____	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
16. 有無任何其他沒有提到的疾病? (Other disease?) ----- 有的話, 是 (yes) _____	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

請簽名 (Signature) XXXXXXXXXX

# 牙科門診記錄

Chief Complaints: 牙左上层內側, 左下後面之牙之牙肉, 上面前牙肉爛掉

P.I.

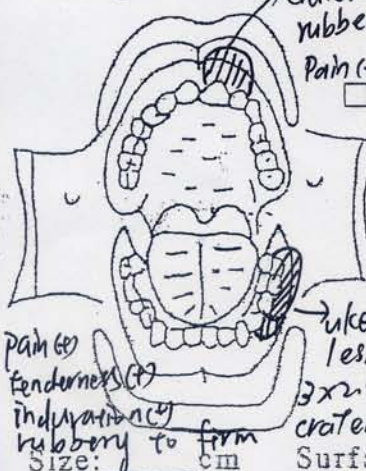
Age	Sex	Date of onset	Character & Location	Refer from	Previous Treatment
		兩, 三禮拜前	左上层mulosa, 167之颊, III		

P.T. 十幾年前在上前牙處作了RPD, 在左下167有作metal crown, 在兩, 三禮拜前, 在左上层mulosa 167之 buccal gingiva 8 III之 palatal side 三處有 ulceration。兩, 三禮拜以來, 167 之 ulceration 越來越嚴重。此三處都沒咬過到過。三處都會痛。除了 III 之 palatal side 無 tenderness 外, 其他

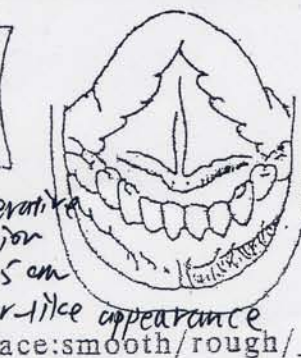
O.E.:

- Character of pain  dull  sharp
  - throbbing  radiated
  - percussion
- Food impaction
- Plaque or calculus deposition
- Gingival swelling
- Gingival bleeding
- Teeth mobility Grade \_\_\_\_\_
- Abscess formation
- Sensitivity to  cold water
  - hot water
  - inhaled air
- Clicking sound from joint (R't, L't)
- Muscle tenderness \_\_\_\_\_
- Improper  restoration  C&B  RPD  CD
- Poor masticatory function
- Poorly phonetic
- Unesthetic teeth or restoration \_\_\_\_\_
- Diastema or spacing
- Loose C&B \_\_\_\_\_
- Sharp edge of teeth (trauma to cheek or tongue)
- Facial asymmetry
- Clinical profile  straight  convex  concave
- Occlusion  class I  class II  class III
- Deep bite
- Open bite  ant.  post.
- Crossbite  ant.  post.
- Crowding  ant.  others
- Tipping \_\_\_\_\_

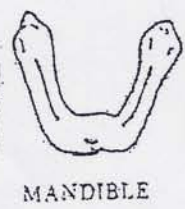
2x2 cm ulcerative surface crater-like appearance rubbery consistency Pain (-), tenderness (+)



Size: \_\_\_\_\_ cm  
Shape: nodule/dome/polypoid/\_\_\_\_\_  
Consistency: soft/cheesy/rubbery/firm/hard/\_\_\_\_\_  
Mobility: movable/fixed/\_\_\_\_\_  
Induration: +/-/?

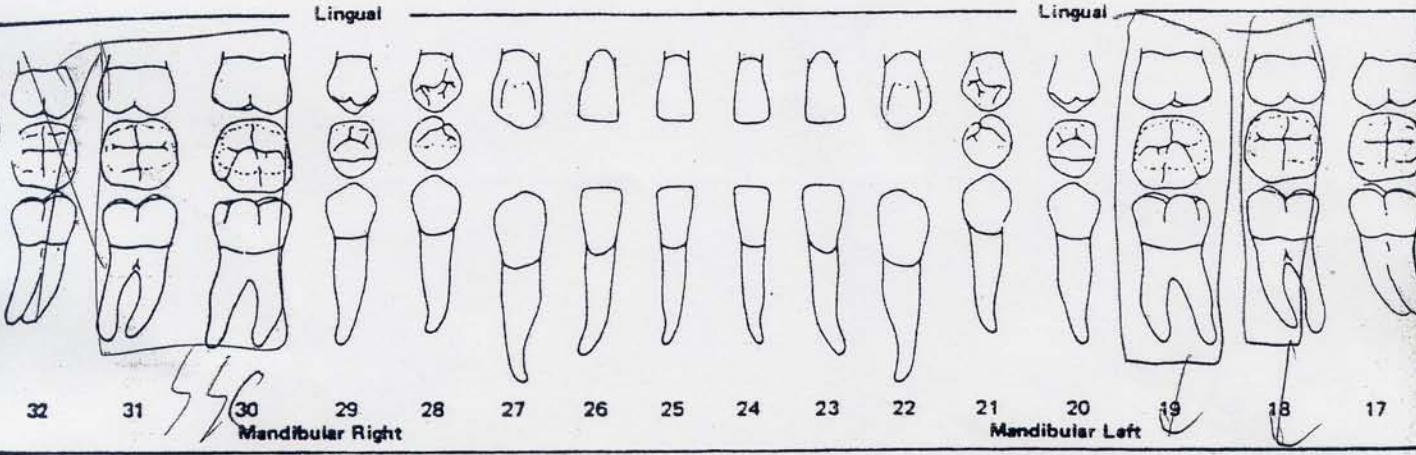
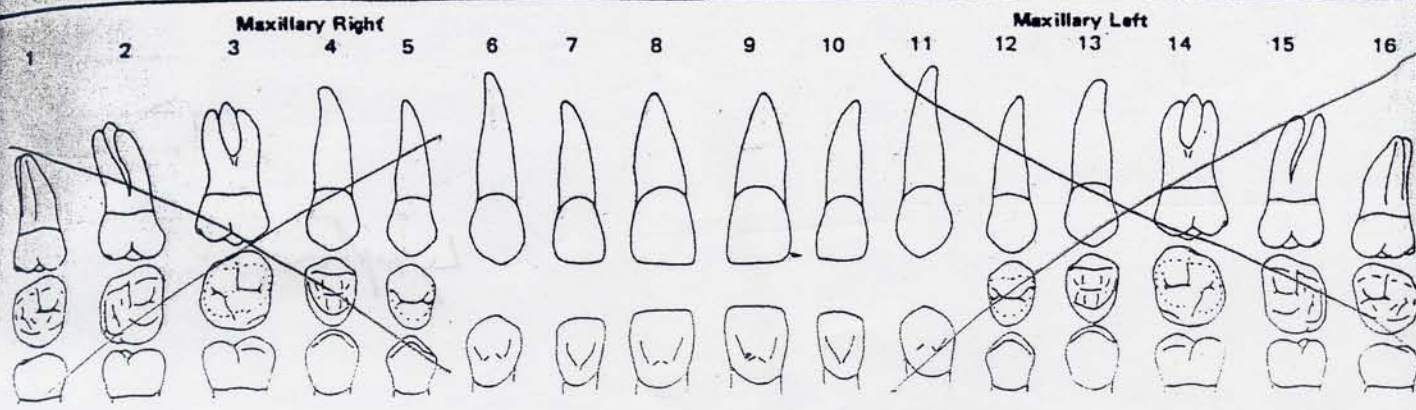


Surface: smooth/rough/\_\_\_\_\_  
Base: pedunculated/sessile



口腔癌患者, 請務必填寫: TNM: T \_\_\_ / N \_\_\_ / M \_\_\_ Stage I/II/III/IV

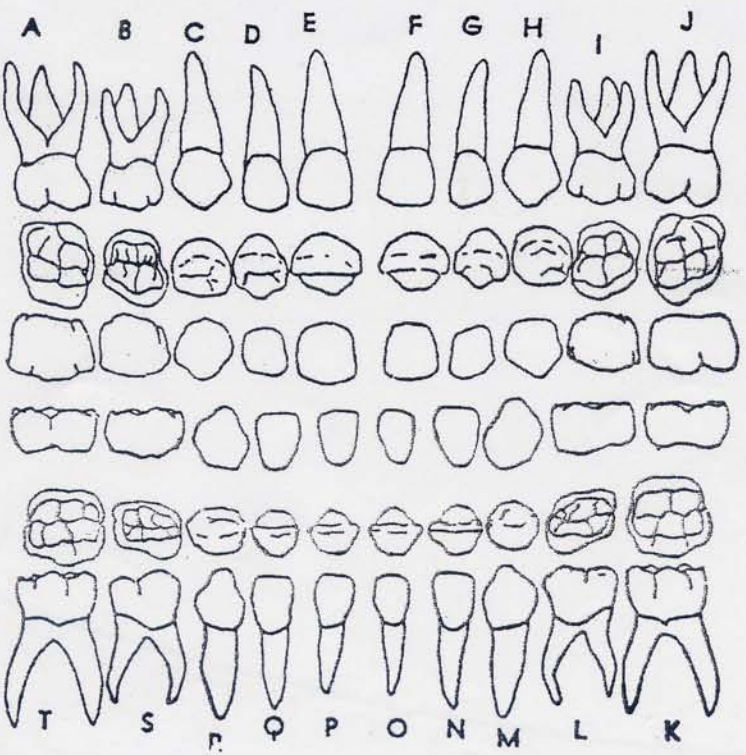
其他都... tenderness 有... 之左... 有一65mm... tend...



Handwritten notes on the left margin: 7/1, 1, 10, 20, 6, MZ, P, 100.

Handwritten notes 'ESC SSC' on the right margin.

- A—Amalgam
- C—Composite
- .—Cement
- F—Gold Foil
- PC—Porcelain Crown
- AFC—Acrylic Face Crown
- FGC—Full Gold Crown
- SSC—Stainless Steel Crown
- FB—Fixed Bridge
- RPD—Removable Partial Denture
- FD—Full Denture



- D--Decay
- R.R. residual root
- Residual root
- X Missing
- + Impacted
- | Unerupted
- ✱ Malposed
- ~ Rotated
- ⊙ Ectopic Eruption
- I: Mobility Grade I
- II: Mobility Grade II
- III: Mobility Grade III

Right

Left



