

Case 4

高醫牙科門診記錄 (Dental Chart)

病歷號碼 Chart No: XXXXX Insurance Yes No
 姓名 Name: XXX 性別 Sex: 女 出生日期 Birthday: 20 年 1 月 15 日
 籍貫 Native: 台南 婚姻狀況: 已婚 未婚 初診日期 First visit: XXXX 月 日
 職業 Occupation: 電話 Tel: 00000000 血型 Blood type:
 地址 Address: 高縣岡山鎮信義路官醫院路37巷16號

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?) <u> </u>				

- 健康問題：請仔細據實回答下列問題，請於空格處鉤選 Yes No Unknown
- 你有下列疾病嗎？(Do you have the following diseases?)
- | | 有 | 無 | 不詳 |
|--|-------------------------------------|-------------------------------------|--------------------------|
| 1. 肝炎或肝病 (hepatitis, liver disease) ----- | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 2. 腫瘤或癌症 (neoplasm, cancer) ----- | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 3. 心臟病, 心律不整 (heart disease, arrhythmia) ----- | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 4. 高血壓 (hypertension, high blood pressure) ----- <u>with drug control.</u> | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. 甲狀腺疾病 (thyroid disease) ----- <u>130~140.</u> | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 6. 肺結核 (tuberculosis) ----- | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 7. 腎臟病 (renal disease) ----- | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 8. 糖尿病 (diabetes mellitus) ----- | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 9. 血液疾病 (blood disorder) ----- | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input 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? ----- | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 為什麼住院? (Why?) <u>乳癌</u> | | | |
| 13. 您曾有過過敏的經驗嗎? Do you have drug allergy history? ----- | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 何種藥物或其他過敏物? (Name of drug) <u> </u> | | | |
| 14. 您目前正在服用藥物嗎? (包含情緒及精神方面的藥物) ----- | <input checked="" type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| (Do you have medication currently? Include psychiatric drug?) | | | |
| 為什麼服藥 (Why?) <u> </u> 服用多久了 (How long?) <u> </u> | | | |
| 藥名 (Drug name?) <u> </u> | | | |
| 15. 您曾經接受過放射線治療嗎? (不含一般檢查用的 X 光) ----- | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| (Do you have received radiotherapy?) | | | |
| 治療部位 (Region?) <u> </u> 治療多久 (How long?) <u> </u> | | | |
| 16. 有無任何其他沒有提到的疾病? (Other disease?) ----- | <input type="checkbox"/> | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| 有的話, 是(yes) <u> </u> | | | |

請簽名 (Signature)

牙科門診記錄

Chief Complaints: ¹ exophytic mass over the hard palate ² swelling over Lt:

P.I.

Age	Sex	Date of onset	Character & Location	Refer from	Previous Treatment
66		7 6 month.	Lt hard palate.		incisional biopsy

² 2 month

- This 66 y/o female suffered above episode 1. for about 6 month. (painless). She went to 義大 for help and accepted incisional biopsy (pt said 良性). Today she comes to our OPD for further evaluation. Lt face swell until 義大 incisional biopsy 後. pain when opening mouth.

O.E.:

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

口腔內是否有特殊病灶，如有請圖示位置及填寫以下各欄位：



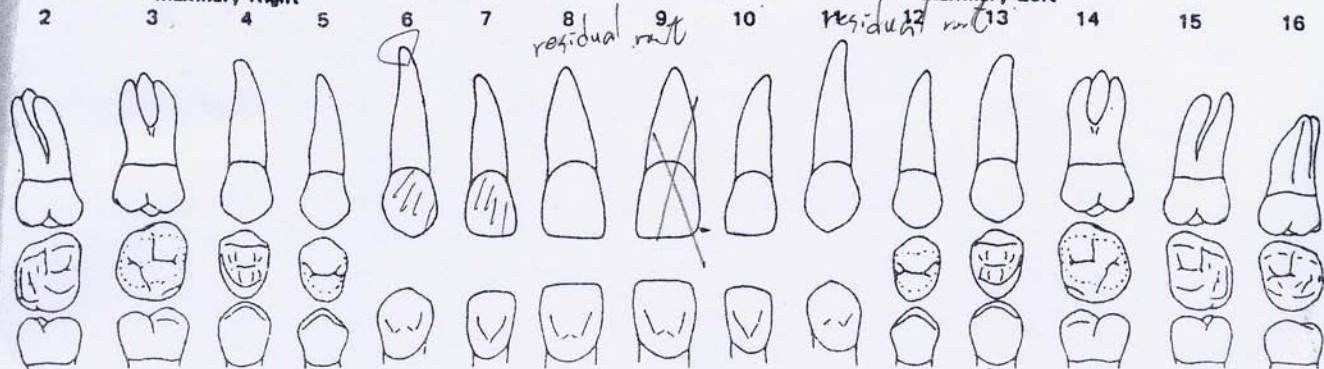
Size: 5x3 cm Surface: smooth/rough/_____ Base: pedunculated/sessile
 Shape: nodule/dome/polypoid/_____ Color: white/red/yellow/blue/_____
 Consistency: soft/cheesy/rubbery/firm/hard/_____ Fluctuation: + (-)?
 Mobility: movable/fixed/_____ Pain: + (-)? Tenderness: + (-)?
 Induration: + (-)? Lymphadenopathy: +/-/specify _____

口腔癌患者，請務必填寫：TNM: T___/N___/M___ Stage I/II/III/IV

² pain when opening mouth.

Maxillary Right

Maxillary Left



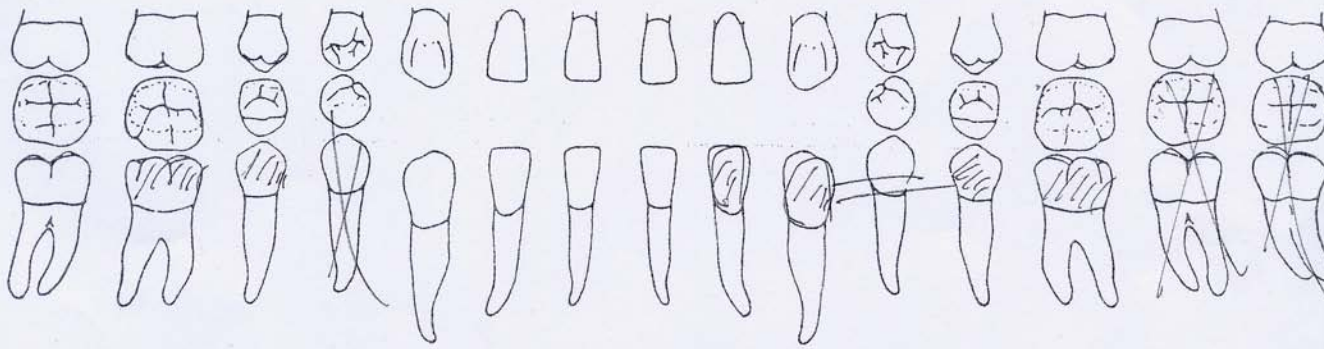
caries

Lingual

Lingual

occlusal

lingual



32

31

30

29

28

27

26

25

24

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22

21

20

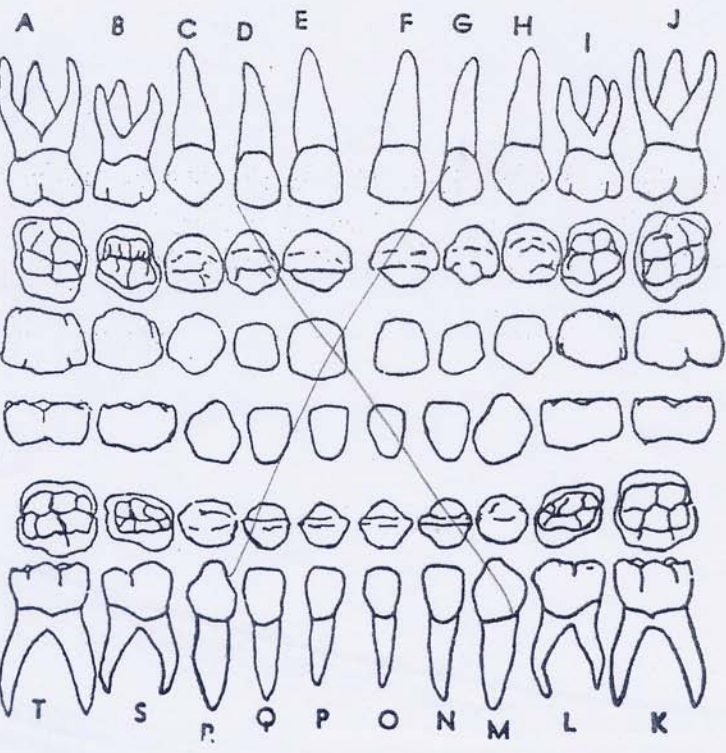
19

18

17

Mandibular Right

Mandibular Left



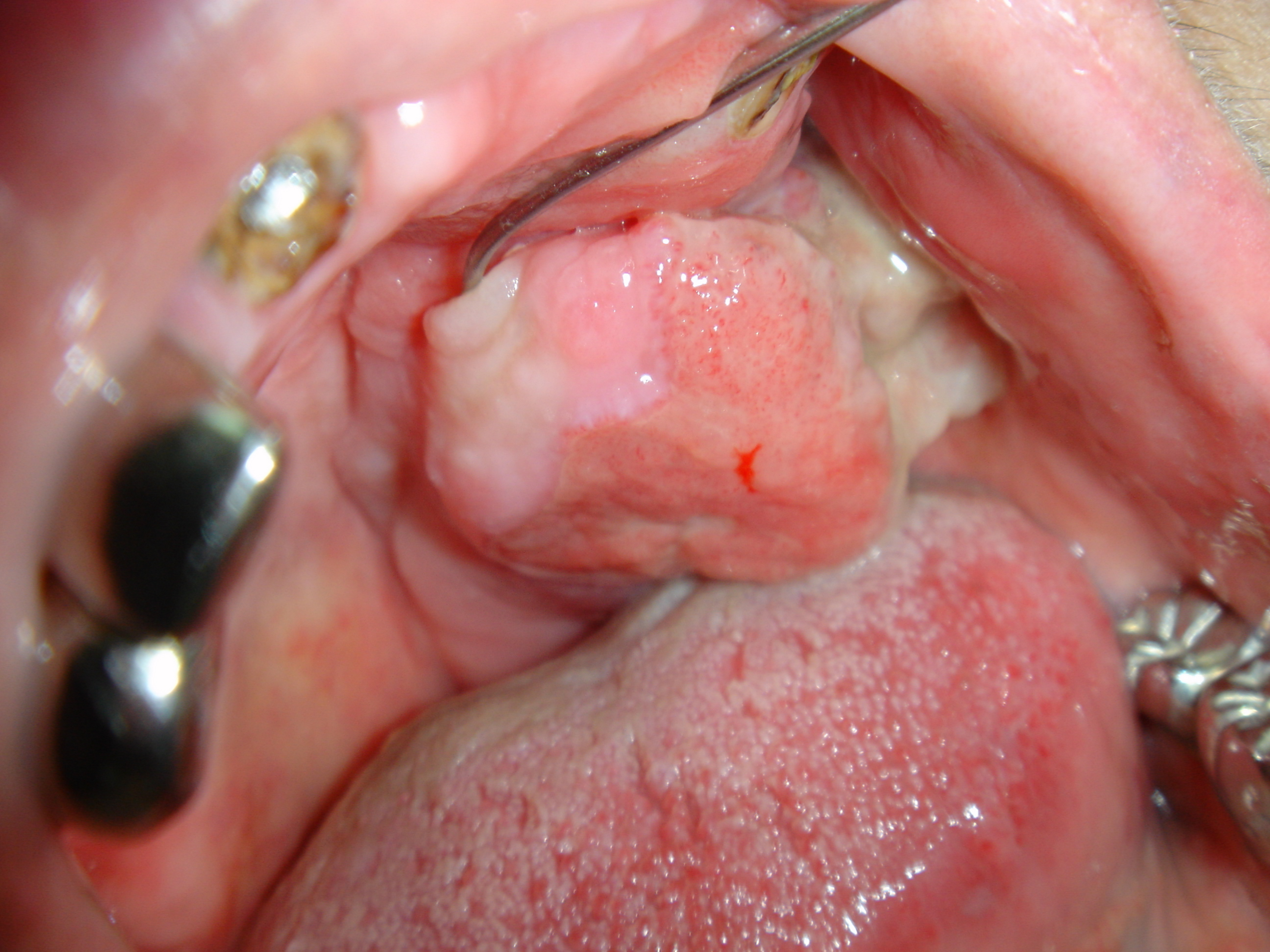
- Amalgam
- Composite
- Cement
- Gold Foil
- Porcelain Crown
- Acrylic Face Crown
- Full Gold Crown
- Stainless Steel Crown
- Fixed Bridge
- Removable Partial Denture
- Full Denture

- D--Decay
- R.R. residual root
- ⊗ Missing
- + Impacted
- | Unerupted
- ✦ Malposed
- ~ Rotated
- ∩ Ectopic Eruption
- I : Mobility Grade I
- II : Mobility Grade II
- III : Mobility Grade III

Right

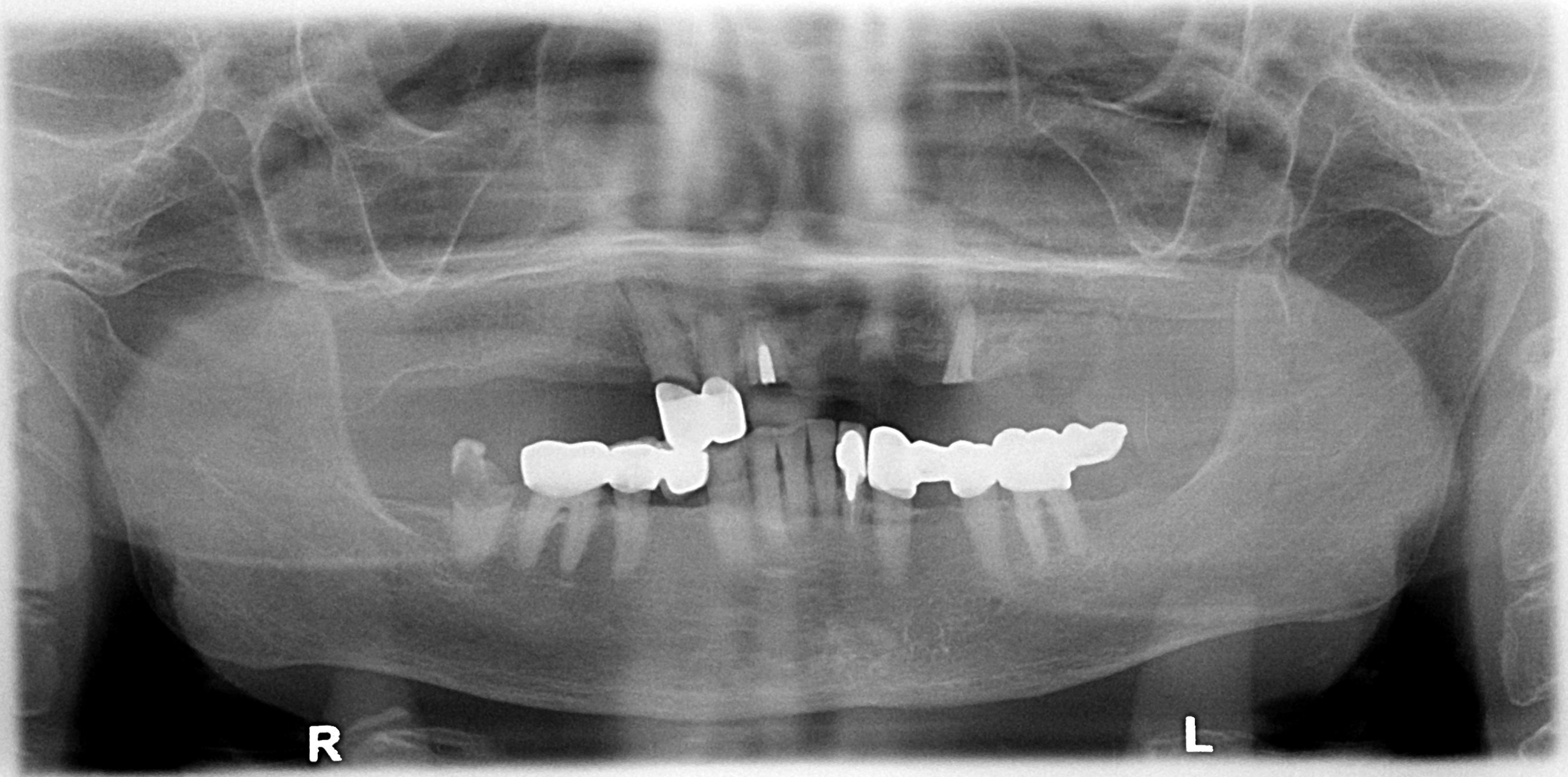
Left





A dark, textured, fan-shaped object, possibly a piece of leather or a book cover, with a white letter 'a' in the bottom right corner. The object has a pebbled texture and is set against a light background. The letter 'a' is white and lowercase, positioned in the bottom right corner of the dark area.

a



R

L