

# 高醫牙科門診記錄 (Dental Chart)

牙科專用

病歷號碼 Chart No. : Case 4 Insurance Yes No  
健保 一般  
 姓名 Name : \_\_\_\_\_ 性別 Sex : 男 出生日期 Birthday : \_\_\_\_\_ 年 \_\_\_\_\_ 月 \_\_\_\_\_ 日  
 籍貫 Native : \_\_\_\_\_ 婚姻狀況:  已婚  未婚 初診日期 First visit : \_\_\_\_\_ 年 \_\_\_\_\_ 月 \_\_\_\_\_ 日  
Marital status yes no yr mon day  
 職業 Occupation : 退休 電話 Tel : \_\_\_\_\_ 血型 Blood type : \_\_\_\_\_  
 地址 Address : \_\_\_\_\_

|                           |  |
|---------------------------|--|
| Medical Alert<br><br><br> | 抽煙 <input checked="" type="checkbox"/> 有(yes) , 無(no) 多久 <u>戒很久</u><br>Smoking 每日數量 _____ 包, 目前有, <input checked="" type="checkbox"/> 無抽<br>喝酒 <input checked="" type="checkbox"/> 有(yes) , 無(no) 多久 <u>戒很久</u><br>Alcohol 每日數量 _____ 瓶, 目前有, <input checked="" type="checkbox"/> 無喝<br>吃檳榔 有(yes) , <input checked="" type="checkbox"/> 無(no) 多久 _____<br>Betel quid 每日數量 _____ 顆, 目前有, 無吃<br>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) -----
  2. 腫瘤或癌症 (neoplasm, cancer) -----
  3. 心臟病, 心律不整 (heart disease, arrhythmia) -----
  4. 高血壓 (hypertension, high blood pressure) -----
  5. 甲狀腺疾病 (thyroid disease) -----
  6. 肺結核 (tuberculosis) -----
  7. 腎臟病 (renal disease) -----
  8. 糖尿病 (diabetes mellitus) -----
  9. 血液疾病 (blood disorder) -----
  10. 性病 (sexual transmitted disease) -----
  11. 懷孕 (pregnancy currently) -----
  12. 您過去有沒有住過院? Have you been hospitalized? -----     
 為什麼住院? (Why?) 靜脈栓塞
  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) \_\_\_\_\_
  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?) 一星期  
 藥名 (Drug name?) 抗凝劑
  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?) \_\_\_\_\_
  16. 有無任何其他沒有提到的疾病? (Other disease?) -----     
 有的話, 是 (yes) \_\_\_\_\_

請簽名 (Signature) \_\_\_\_\_

# 牙科門診記錄

Chief Complaints: Unhealing extraction wound and ulceration, sore throat  
for 2-3 months.

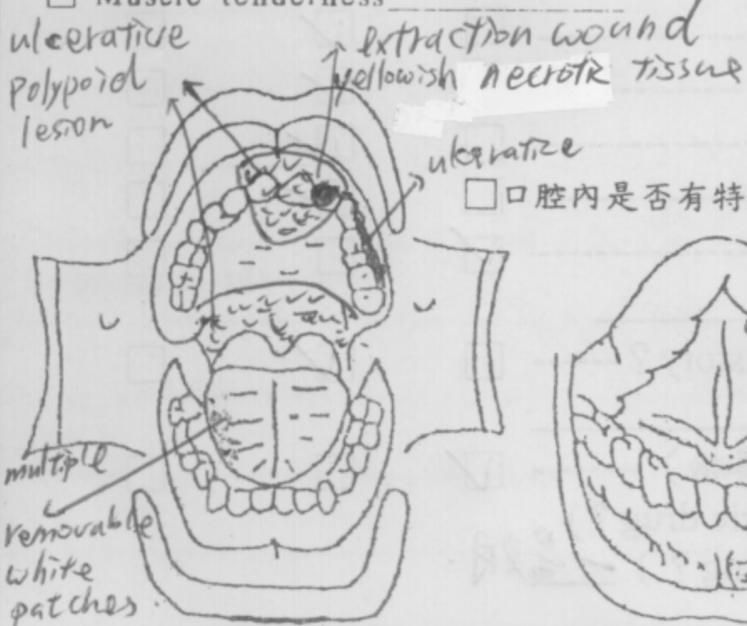
P.I.

| Age | Sex | Date of onset | Character & Location                                 | Refer from | Previous Treatment |
|-----|-----|---------------|--|------------|--------------------|
| 82  | B.  | 2-3 months    | Ulceration over upper anterior arch and soft palate. | 內科         | 曾用蜂膠治療<br>已停用      |

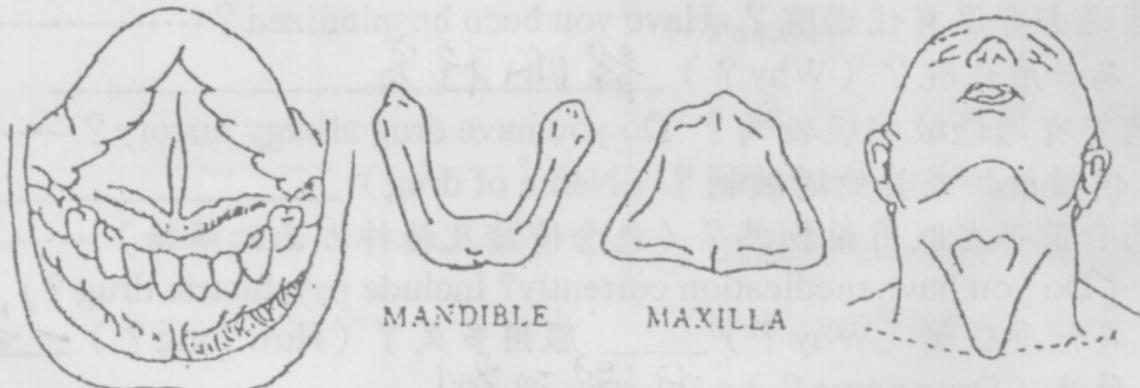
This 82 y/o male had tooth (22) extraction 2-3 months ago. The extraction wound did not heal and ulcerative lesions started to appear. His son gave him 蜂膠 to use but no improvement was noted. Recently he felt severe pain when swallowing and could not eat. He came to ~~visit~~ visit 內科 due to deep vein thrombosis and was referred to our OPD for the

O.E.:

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

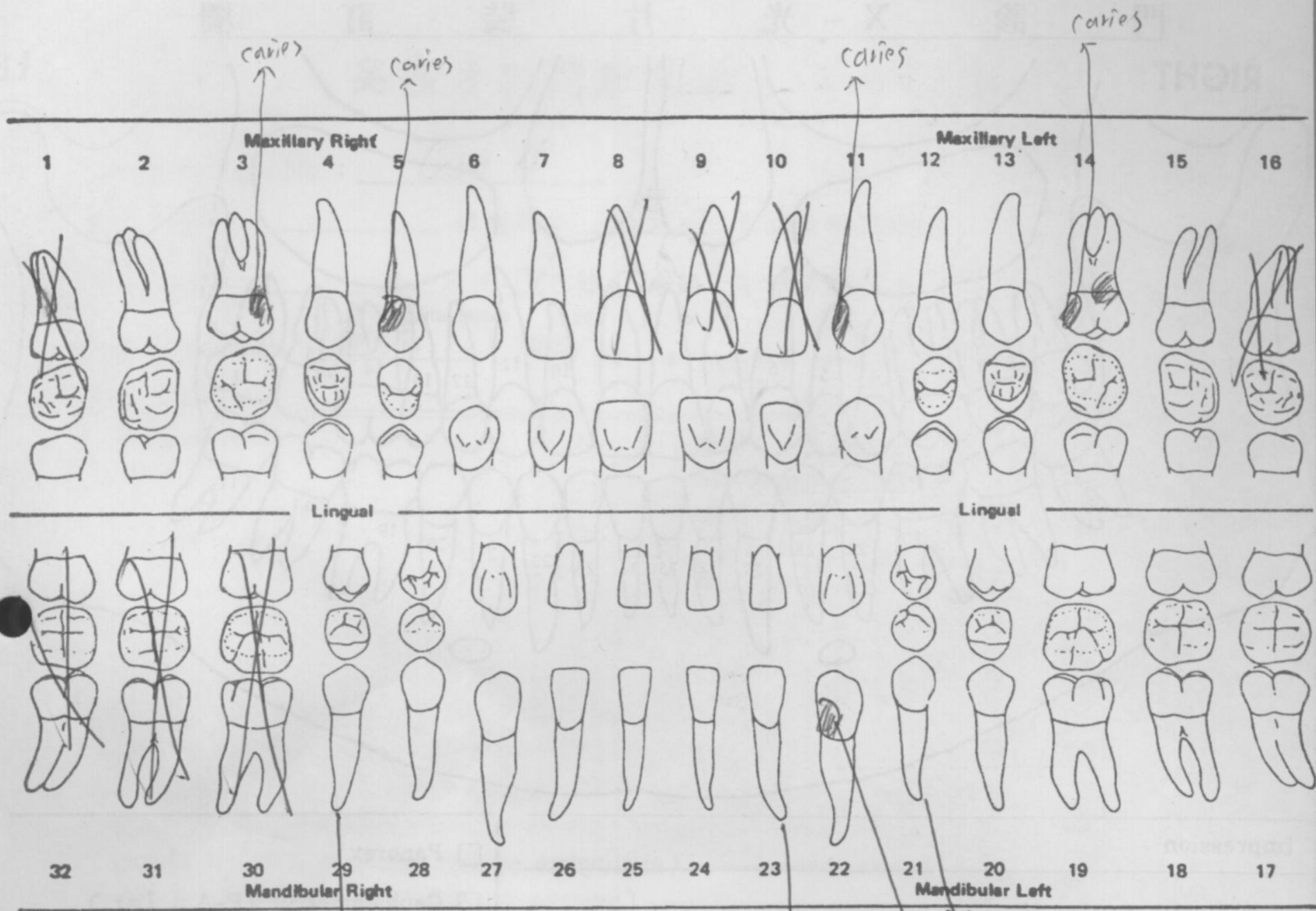


口腔內是否有特殊病灶，如有請圖示位置及填寫以下各欄位：

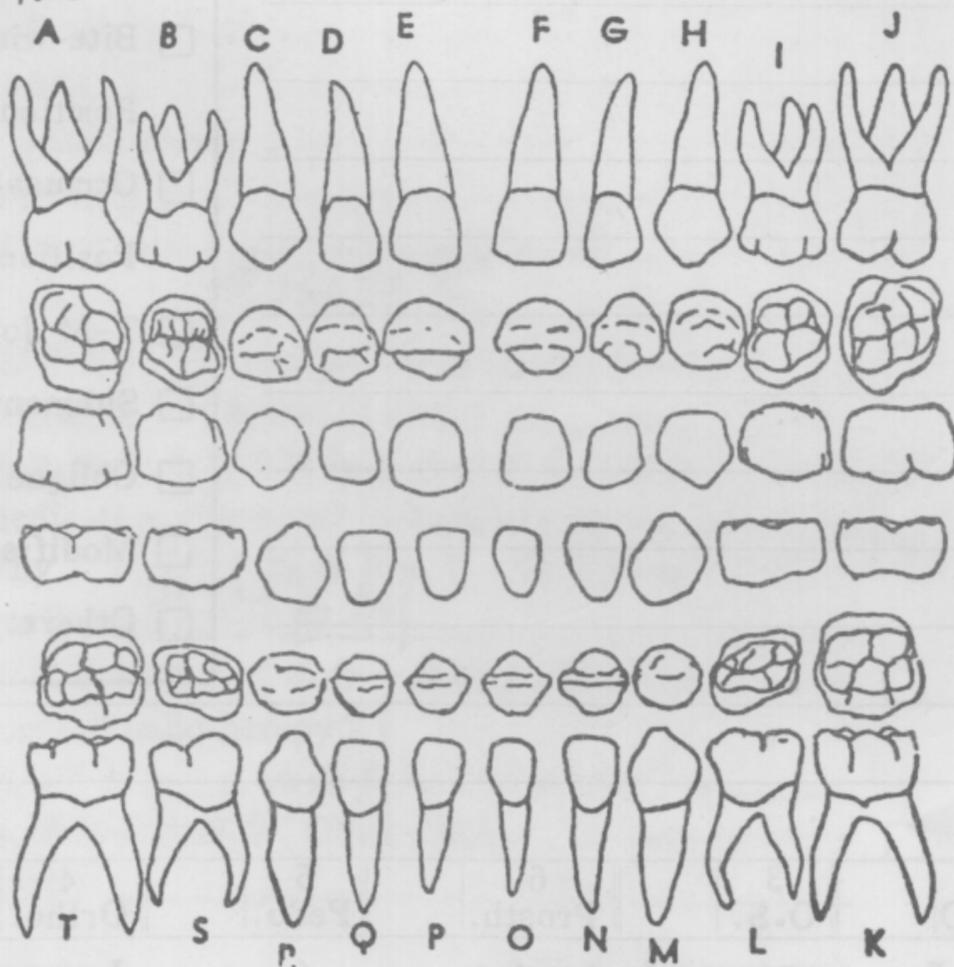


Size: 4 x 2 cm Surface: smooth/rough/ulcerative Base: pedunculated/sessile  
 Shape: nodule/dome/polypoid/\_\_\_\_\_ Color: white/red/yellow/blue/\_\_\_\_\_  
 Consistency: soft/cheesy/rubbery/firm/hard/\_\_\_\_\_ Fluctuation: +  ?  
 Mobility: movable/fixed/\_\_\_\_\_ Pain  /-/? Tenderness: +  ?  
 Induration: +  ? Lymphadenopathy: +  specify \_\_\_\_\_

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



- 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
- ⊗ Missing
- + Impacted
- | Unerupted
- ✱ Malposed
- ~ Rotated
- ∞ Ectopic Eruption
- I: Mobility Grade I
- II: Mobility Grade II
- III: Mobility Grade III

Right

Left









