DATE: NAME: RN: Staff:

Medical History Form

Please fill in the medical history below:- We need to know your current health condition, to provide suitable dental care.
All the information provided is strictly confidential. If you have any problem, please ask our receptionist for assistance.
(Please fill in □ with / where applicable, if 'Yes' please specify.)

No, my body and mind are healthy, I do not want to give any information regarding my health, but I insist the dentist to treat me. I agree that in the future the dentist has no responsibility to ask for my medical history unless I tell the voluntarily.	□ I refuse to fill in my data/info
1.Have you ever been hospitalized? If 'Yes' please give details: □Sickness □Operation □Childbirth □Other:......	□Yes □No
2. Do you have or ever had the following diseases or problems? If 'Yes' please specify: □Heart □Liver □Kidney □Lung □Asthma □Blood □G6PD □Cancer/Chemo/radiation therapy □Jaundice □Epilepsy or Fainting □Other please specify:	□Yes □No
3. Do you have or ever had diabetes?	□Yes □No
4. Do you have or ever had high blood pressure?	□Yes □No
5. Do take medicines regularly (other than tonic)? If yes, please specify the name of medicines or what are the pourposes:	□Yes □No
6. Female: 6a.) Are you pregnant or expecting a baby? 6b.)Are you breastfeeding your baby? 6c.)Are you on the contraceptive pill? NOTE: If you are likely to be pregnant on you next time to this clinic, please let the dentist know immediately.	 □Yes □No □Yes □No □Yes □No
7. Do you have or ever had any infection disease? □Hepatitis(B/A) □AIDS/ HIV □Tuberculosis (TB) □Sexually transmitted diseases (eg. Syphilis, gonorrhea etc.)	□Yes □No
8. Do you (a)bruise easily or (b)bleeding excessively when you are cut?	□Yes □No □Yes □No
9. Do you allergic to anything? If 'Yes' please specify: □Medicine:.... □Rubber:.... □ Food:.... □Metal:.... □ Other please specify:	□Yes □No
10. Do you have the following habit(s)? If 'Yes' please specify: □Drinking Alcohol □Smoking □Pinang (Betel nut) chewing	□Yes □No
11. Have you encounter any complication or side effect at previous dental treatment? □Pain □Swelling □Prolonged bleeding □Phobia/Afraid □Other please specify:	□Yes □No

If you have any ailments which are not included above, please inform the dentist.
I further declare that I will report any changes in my health, including any medication taken within the last 14 days, infection diseases, illness, allergies and operation to the dentist whom I may consult from.
For persons under 18 years, parent/guardian will be responsible to report the child's health. The signature of the parent/ guardian affixed below will be taken as consent for treatment.

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Signature of ** Self/Father/Mother/Guardian (** delete as necessary)

病历表格

我们需要了解阁下之健康状况，以便在牙齿保健时，能采取最适当之治疗。如有问题请询问柜台的接待员。阁下提供的资料将被视为机密。(请在有关的空格 □ 写 /)

我身心健康, 我不愿意提供我的健康资料, 但是仍然要牙科医生治疗。我同意以后牙医没有义务询问我的病历, 除非我主动告知。	□不愿意提供资料
1. 您是否住过医院？若'有'请写明:- □疾病 □手术 □生产 □其它(请写明):	□有 □无
2. 您曾经患过下列的病症/问题吗? 若'有'请写明: □心脏病 □肝脏病 □肾脏病 □肺脏病 □哮喘 □血液病 □G6PD □癌症/化疗/电疗 □黄疸病 □癫痫/昏迷 □其它(请写明):	□有 □无
3.您是否有糖尿病?	□有 □无
4.您是否有高血压?	□有 □无
5.您是否有长期吃药(除了补药/维生素)? 若'有'请写明药名或用处:……..	□有 □无
6.女性: 6a.您是否正在怀孕或预备怀孕? 6b.您是否正在喂为孩子喝人奶? 6c.您是否有吃或使用避孕剂? 注意: 下一次复诊时有怀孕请告诉牙医。	 □有 □无 □有 □无 □有 □无
7.您是否有任何的传染病? 若'有'请写明: □肝炎(B/A) □爱滋病 (AIDS/HIV) □肺结核(TB) □性病 (如:梅毒,淋病等) □其它(请写明):	□有 □无
8.您容易有 (a)瘀肿或 (b)流血止不吗?	□有 □无 □有 □无
9.您有对什么东西过敏/敏感吗? 若'有'请写明:- □药物:…… □.橡胶:…… □食物:…… □金属:….. □其它:…….	□有 □无
10. 您有下列的习惯吗? 若'有'请写明:- □喝酒 □吸烟 □吃槟榔	□有 □无
11.您以前在治疗牙齿是否有任何并发症/问题? 若'有'请写明:- □疼痛 □肿胀 □流血难止 □恐惧症 □其它:…….	□有 □无

如果您患有上述以外之病痛, 请通知牙医。
我会在每次治疗前通知我的牙医, 关于我最新的健康状况: 疾病, 传染病, 敏感, 手术, 最近 14 天所用或,吃过的药,
凡十八岁以下，其父母或监护人将负责向牙医报告孩童之健康状况，其下之签名将作为同意接受治疗。

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**本人/父亲/母亲/监护人签名
**请删除不适用字句

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