SOUTHSIDE DENTAL LTD

HEALTH INFORMATION FOR ORTHODONTIC TREATMENT

Please answer to the best of your knowledge and tick the appropriate box (elaborate if necessary). This form is for our office records and is strictly confidential. A thorough & complete health history is vital to a proper orthodontic evaluation.

Patient Name:	**Date of Birth:**

		MEDICAL HISTORY			**DENTAL HISTORY**
☐ Y	☐ N	Birth defects/hereditary problems? 出生缺陷/遺傳病	☐ Y	☐ N	Chipped/fractured teeth? 崩牙/斷牙
☐ Y	☐ N	Fainting spells/seizures/epilepsy? 昏暈/抽筋/羊癇症	☐ Y	☐ N	Teeth sensitive to hot/cold? 牙齒敏感
☐ Y	☐ N	Rheumatoid/arthritic conditions? 風濕/關節炎	☐ Y	☐ N	Bleeding gums? 牙肉流血
☐ Y	☐ N	Endocrine/diabetes/thyroid problems?内分泌/糖尿/甲狀腺	☐ Y	☐ N	Root canal treatment? 導牙根
☐ Y	☐ N	Kidney problems? 腎病	☐ Y	☐ N	Wisdom teeth problems? 智慧齒問題
☐ Y	☐ N	Cancer/treated for a tumor? 癌症/曾接受腫瘤治療	☐ Y	☐ N	Jaw clicking/pain? 牙骸痛
☐ Y	☐ N	Hepatitis/jaundice/liver problem? 肝炎/黃胆/肝病	☐ Y	☐ N	Regular dental maintenance? 定時牙科檢查
☐ Y	☐ N	Stomach/bowel problems? 胃/腸病	☐ Y	☐ N	Thumb/finger sucking habit? 啜手指
☐ Y	☐ N	Bleeding diorders? 流血不止	☐ Y	☐ N	Abnormal swallowing habit? 不正常吞嚥習慣
☐ Y	☐ N	High/low blood pressure? 高/低血壓	☐ Y	☐ N	Teeth grinding/jaw clenching? 磨牙/咬牙
☐ Y	☐ N	AIDS/HIV positive? 愛滋病	☐ Y	☐ N	Mouth breathing habit/snoring? 口呼吸/打鼾
☐ Y	☐ N	Asthma/hay fever/sinus trouble? 哮喘/花粉症/鼻竇	☐ Y	☐ N	Extra (supernumerary) teeth? 多生牙
☐ Y	☐ N	Heart problems?心臟病	☐ Y	☐ N	Missing teeth? 缺牙
☐ Y	☐ N	Speech problem? 說話困難	☐ Y	☐ N	Concern about underbite/deepbite? 倒及/深咬
☐ Y	☐ N	Rheumatic fever/bacterial endocarditis? 風濕性發熱/細菌性引起心內膜炎	☐ Y	☐ N	Spaced/crooked/protruding teeth? 牙縫隙/牙齒不齊/哨牙
☐ Y	☐ N	Tonsils/adenoid problems? 扁桃腺/腺狀腫	☐ Y	☐ N	Facial asymmetry? 顏面不對稱
☐ Y	☐ N	Allergies/drug reactions? 過敏	☐ Y	☐ N	Play musical instrument with lips? 玩吹奏樂器
☐ Y	☐ N	Currently taking medications? 藥物治療	☐ Y	☐ N	Gag easily? 容易作嘔
☐ Y	☐ N	Previous surgery? 動過手術	☐ Y	☐ N	Previous orthodontic treatment? 接受過矯齒治療
☐ Y	☐ N	Recently hospitalized? 近期入院	☐ Y	☐ N	Problem with previous dental treatment? 過往牙科治療問題
☐ Y	☐ N	Current medical problems? 現時病況	☐ Y	☐ N	Current dental problems? 現有牙科問題

FEMALE ONLY		
☐ Y	☐ N	Could you be pregnant? 懷孕

ADDITIONAL INFORMATION

Note : Successful orthodontic treatment depends greatly upon the patient's full cooperation in following instructions, keeping appointments and maintaining good oral hygiene.

I have read and understood the above questions. Should there be any changes to this history record or medical/dental status in the future, I will inform the practice.

Signature of patient/parent/guardian **Date**