



Name 姓名: \_\_\_\_\_ Phone 電話: \_\_\_\_\_ Tel 手提電話: \_\_\_\_\_

Home Address 地址: \_\_\_\_\_

Date of Birth 出生日期: \_\_\_\_\_ Age 年齡: \_\_\_\_\_

Dental Insurance 牙科保險: 有/ 無      家庭醫生: \_\_\_\_\_ 家庭醫生電話: \_\_\_\_\_

	YES	NO
1. 閣下健康是否不良? Are you in poor general health?		
2. 閣下是否正在接受醫藥治療? Are you receiving medical treatment from your doctor, hospital or clinic?		
3. 閣下現在是否服食任何藥物? Are you taking any medicine, pills or tablets either		
4. 閣下曾否入住醫院或在醫院「門診部」接受治療? Have you attended a hospital previously as an in-patient or out-patient?		
5. 閣下曾否接受「全身麻醉」? Have you ever had a general anesthetic?		
6. 閣下是否對盤尼西林, 食物, 或其他藥物? Are you allergic to penicillin or any other medicine, food or substance?		
7. 曾否患「乾草熱」, 「濕疹」, 或「哮喘」? Do you suffer from any fever, eczema or asthma?		
8. 是否曾患風濕性熱病? Have you ever had rheumatic fever?		
9. 施手術, 拔牙, 或受傷時是否流血不止? Have you ever had abnormal bleeding after extractions, surgery or injury?		
10. 是否服用「類固醇」, 「抗凝血藥物」或「電療」? Have you undergone steroid, anti-coagulant or irradiation therapy?		
11. 是否曾患「黃膽病」, 「肝炎」或其他「肝病」? Have you ever suffered from jaundice, hepatitis or other liver disease?		
12. 是否曾經突然暈倒或常覺得頭暈? Do you have sudden fainting attacks or giddiness?		
13. 兒時曾否患水痘麻疹等症狀? Have you had any childhood diseases?		
14. 是否懷孕? Are you an expectant diseases?		

15. 曾否患下列疾病:

- |  |  |                                       |
|--|--|---------------------------------------|
| Heart Disease <input type="checkbox"/> | Kidney Diseases <input type="checkbox"/> | Tuberculosis <input type="checkbox"/> |
| 心臟病                                    | 腎病                                       | 肺結核                                   |
| Hypertension <input type="checkbox"/>  | Diabetes <input type="checkbox"/>        | Epilepsy <input type="checkbox"/>     |
| 高血壓                                    | 糖尿病                                      | 羊癇                                    |
| Blood Disease <input type="checkbox"/> | Thyroid Disease <input type="checkbox"/> | Stroke <input type="checkbox"/>       |
| 血病                                     | 甲狀腺病                                     | 腦充血                                   |

16. 請述其他有關健康資料予我們知道 Is there any other medical information about which we should know?

Signature \_\_\_\_\_