Medical Questionnaire

Today's date:

Name	Birthday (Y/M/D)&Age	
Address		*Please place check mark on the number you want us to call.*
		☐Home :
E-mail Address		☐Cellphone :
Occupation		☐Workplace :

◆If there should be any special request for the time, day, or period of visit, please write bellow.

(_____)

※Our clinic tries to do what is best for our patients by looking at their mouth comprehensively.

In order to avoid any misunderstanding, please answer the questions bellow as accurate as possible.

If there should be any question, please do not hesitate to ask the doctors or staff members.

1. What is bothering you today? (Please put check marks as many as you like.)

☐ Have a toothache（歯が痛い）

☐ Hurt when biting（咬むと痛い） ☐ Hurt all the time（何もしなくても痛い）

☐ Wisdom teeth aches（親知らずが痛い）

☐ Have a tooth that is sensitive（歯がしみる）

☐ Have shaky, loose teeth（歯がぐらぐらする）

☐ Have swollen gum（歯肉がはれている）

☐ Have gum pain（歯肉が痛い）

☐ Have a cracked or chipped teeth [front teeth / back teeth]（歯が欠けた）

☐ (Dental crown, filling) came off [front teeth・back teeth / bridge]（(詰物･かぶせ物）が取れた）

☐ (Dental crown, filling) Want to clean and make white（詰め物･かぶせ物をきれいにしたい）

☐ Denture broke, or does not fit well（入れ歯が壊れた・合わない）

☐ Want to treat where there is no teeth（歯が無いところを治療したい）

☐ Want to make teeth white（歯を白くしたい）

☐ Want to have dental cleaning（ｸﾘｰﾆﾝｸﾞをしたい）

☐ Want to remove stains from teeth（歯の着色を取りたい）

☐ Worried about teeth alignment（歯並びが気になっている）

☐ Want to correct bite problems（噛み合わせを治したい）

☐ Want to treat the teeth cosmetically（歯を審美的に治したい）

☐ Interested in: ☐ dental implant（ｲﾝﾌﾟﾗﾝﾄ） ☐ orthodontic therapy (矯正治療)

☐ teeth whitening（ﾎﾜｲﾄﾆﾝｸ） ☐ preventive dentistry（予防歯科）

☐ botox（ﾎﾞﾄｯｸｽ）

☐ Others ( )

2. Have you ever received any dental treatment in the past?

☐ No

☐ Yes (last treatment : _____ years ago / place: _____)

3. Have you ever suffered from any abnormality, or felt ill by a dental treatment?

☐ No

☐ Yes (At the time of anesthetic （麻酔時） / extracting a tooth （抜歯時）

Others: _____)

4. Have you ever suffered from any serious illness in the past, or is presently undergoing a medical treatment?

☐ No

☐ Yes: ☐ heart disease（心臓） ☐ pneumonia (Type A / B / C)（肺炎） ☐ kidney disease（腎臓）
☐ diabetes（糖尿） ☐ blood disease（血液系） ☐ thyroid disease（甲状腺）
☐ asthma（喘息） ☐ osteoporosis（骨粗しょう症） ☐ cerebrovascular accident（脳血管障害）
☐ nose disease（鼻） ☐ high / low blood pressure (　　/　　)（高血圧/低血圧）
☐ Others (　　)

5. At present, are you visiting a doctor regularly?

☐ No ☐ Yes: Name of the disease (　　)
Name of the hospital / doctor (　　)

6. Do you take any medicine regularly?

☐ No ☐ Yes: Name of the medicine (　　)
Name of the disease (　　)

7. Do you have any allergies with medicine, food, etc.?

☐ No ☐ Yes (　　)

8. Do you grind your teeth while sleeping?

☐ No ☐ Yes

9. Do you have a habit of smoking?

☐ No ☐ Yes (Approximately _____ times a day from _____ years ago)

10. How often do you brush your teeth?

☐ morning ☐ noon ☐ night

Have you ever received toothbrushing instructions?

☐ No ☐ Yes

11. For female patients: Are you presently pregnant?

☐ No ☐ Yes (In the _____th week) ☐ Possibly Yes ☐ Breast feeding

12. Where did you learn of our clinic?

☐ Introduced from (　　) ☐ Internet ☐ happened to pass by
☐ by word of mouth ☐ received a flyer ☐ e-park ☐ Ekiten
☐ Others (　　)

13. Regarding your treatment:

☐ Whether it is a treatment covered by insurance or not (self pay treatment), I would like to get the best and the most comfortable treatment.
☐ I would like to know what can be done with the self pay treatment.
☐ Even if there is a limit, I would like to proceed with only what can be covered by the insurance.
☐ I would like to decide after consulting.
☐ At present, I cannot decide.

Thank you for the trouble!