Nishiyama□dentalclinic
HEALTH QUESTIONNAIRE

Name : _____ (M/F) Date of Birth : (YY/MM/DD)___／___／___

Address : Postal code _____

Phone No. : _____

《The purpose of your visiting.》 □check please

□Dental check up □Caries prevention □Cleaning/Whitening □Dental calculus removal

Tooth→ □Pain □Loosing a filling(A metal cap or plastic material) □Having a hall
□Sensitive to(Cold/Hot/Sweet) □Stuck something □Getting loose □Grinding
□Hit the tooth

Gum→ □Pain □Inflamed □Bleeding □Pus came out from the gum

Jaw→ □Pain □Sound strange by jointing □Having problem of opening the mouth
□Feeling tired in the morning

□Orthodontic treatment □Mouth odor(Bad breath) □Other

《Please state a spot》

□Upper □Lower □Right side □Left side □Front □Back □All □Other

《Please state when did you have the symptoms》

□From _____day(s)ago □From _____week(s)ago □From _____month(s)ago □Other

《Question about your systemic disease》

□Do you have any disease? Yes/No

If yes, please state. □check please

□Disease of heart □Disease of Kidney □Diabetes(hemoglobin A1c___%) □Disease of Liver
□Hypotension □Anemia □Hypertension □Asthma □Other_____

Do you have any allergy? Yes / No If yes, please state. I am allergic to
①Medicine_____ ②Metal_____ ③Rubber_____ ④Food_____ ⑤Other_____

Do you have a pacemaker? Yes / No

Have you ever had abnormal bleeding from an injury or tooth extraction? Yes / No

Have you ever had reaction during dental treatment or injection for anesthesia? Yes / No

Do you smoke? Yes / No

Are you taking any medicine or drug? Yes / No

If yes, please state the name of the medicine_____

Especially □Warfarin・Asprin □osteoporosis.

About anticancer therapy. If yes, please check □radiation □chemotherapy

《Please check、when you are now about the illness of blood even if Carrier or before.》

□Blood has been transfused. □Dialysis □Hepatitis B □Hepatitis C

□human immunodeficiency virus □another blood disease

《It is a question at a woman.》

Are you pregnancy? Yes / No / Not sure If yes, please state the month. _____month(S)

DO you breast feed? Yes / No