KAWAZU DENTAL CLINIC
Shinjuku Nomura Building 5F
26-2, 1-Chome, Nishishinjuku, Shinjuku-ku, Tokyo, 160, Japan
Telephone : (3 4 6) 2 2 5 8

PATIENT INFORMATION

You are requested routinely to fill out the following questions so that we can have an accurate date about your problems and personal feelings. In order to diagnose thoroughly under any condition, the doctor must have accurate informations, and he may give a personal attention to each patient. These informations are surely confidential.

Thank you.

Name : _____ Age : _____

Date of Birth : _____ Nationality : _____

Employer : _____

Business Address : _____

Business Phone : _____

Occupation : _____

Home Address : _____

Home Phone : _____

Please answer the following questionnaire.

*	Are you in good health ?		YES	NO
*	When was your last check up ?	(		)
*	Are you being seen by a physician now ?		YES	NO
*	Are you allergic to any medicine ?		YES	NO
*	Have you ever had a major disease ?		YES	NO
*	Are you taking any medication ?		YES	NO
*	How long has it been since your last visit to a dentist ?	(		)
*	What kind of work was done at that time ?	(		)
*	Treatment Desired : Thoroughly	(		)
	Emergency only	(		)

1. Does your dental health effects your physical health ? YES NO
2. Are you satisfied with the appearance of your teeth ? YES NO
3. Do you have any concern for having a treatment ? YES NO
4. Do you have any difficulty in biting or chewing foods ? YES NO
5. Do you have any tooth which is sensitive to sweet or cold ? YES NO
6. Does your gum bleed ? YES NO
7. Does it take time to cure the wound in your mouth or lips ? YES NO
8. Have you noticed that the space between teeth becomes wider ? YES NO
9. Have you noticed your bite changing ? YES NO
10. Do you clench or grind your teeth ? YES NO
11. Have you ever had your bite adjusted ? YES NO
12. Do you have difficulty in opening your mouth wide ? YES NO
13. Do you have pain in or near your ears ? YES NO
14. Have you ever been told that you had gum trouble ? YES NO
15. Have you ever been treated for periodontal disease (Pyorrhea) ? YES NO
16. Have you ever had orthodontic treatment (braces) ? YES NO
17. Have you had any complication associated with any previous dental treatment ? YES NO
18. Do you now or have you ever had sinus trouble ? YES NO
19. Have you ever had any injury to your face or jaws ? YES NO
30. Have you been examined by your physician within the last year ? YES NO
21. Are you being treated for any condition by a physician now ? YES NO
22. Have you been taking any medicines within the past year ? YES NO
23. Has there been any change in your general health in the past year ? YES NO
24. Have you lost or gained weight in recent months ? YES NO
25. Have you ever been seriously ill ? YES NO
26. Have you ever been hospitalized ? YES NO
27. Have you ever had surgery ? YES NO
28. Have you ever had a blood transfusion ? YES NO
29. Have you ever had x-ray or surgery treatment for a tumor, growth or other conditions about your head, mouth, or on your lips ? YES NO
30. Have you ever been treated for a growth or tumor in any other part of your body ? YES NO
31. Are you frequently ill ? YES NO
32. Do you often feel exhausted or fatigued ? YES NO
33. Have you ever had any of the following diseases or conditions :

A. Jaundice (yellow skin & eyes)	YES	NO	J. Measles	YES	NO
B. Hepatitis	YES	NO	K. Chicken pox	YES	NO
C. Tuberculosis	YES	NO	L. Mumps	YES	NO
D. Venereal disease	YES	NO	M. Polio	YES	NO
E. Heart attack	YES	NO	N. Rheumatic fever	YES	NO
F. Stroke	YES	NO	O. Scarlet fever	YES	NO
G. Ulcers	YES	NO	P. Glaucoma	YES	NO
H. Epilepsy	YES	NO	Q. Prostate Disorders	YES	NO
I. Diabetes (sugar disease)	YES	NO			

34. As a child, did you have growing pains or twitching of the limbs ? YES NO
35. Have you ever had painful or swollen joints ? YES NO
36. Have you ever been told by a physician that you have a heart murmur ? YES NO
37. Do you now have or have you ever had any heart trouble ? YES NO

38. Do you have high blood pressure ? YES NO
39. Do you bleed for a long time when you cut yourself ? YES NO
40. Do you bruise easily ? YES NO
41. Do you have any blood disorder such as anemia (thin blood) ? YES NO
42. Do you have any chest pain on exertion ? YES NO
43. Are you ever short of breath on mild exertion ? YES NO
44. Do you ankles ever swell ? YES NO
45. Do you have a persistent cough ? YES NO
46. Do you ever have asthma ? YES NO
47. Do you ever have hay fever ? YES NO
48. Do you have any allergies (to food, cat's fur, dust, etc.) ? YES NO
49. Do you ever have hives or skin rash ? YES NO
50. Have you ever experienced an unusual reaction to any of the following drugs :

A. Penicillin	YES	NO	D. Iodine	YES	NO
B. Barbiturates (sleeping pills)	YES	NO	E. Sulfa drugs	YES	NO
C. Aspirin	YES	NO	F. Other medicines	YES	NO

51. Have you ever experienced an unusual reaction to a dental anesthetic ("Novocaine" injection) ? YES NO
52. Do you often have to get up at night to urinate ?
53. During the day, do you usually have to urinate frequently ? YES NO
54. Are you thirsty much of the time ? YES NO
55. Has anyone in your family ever had diabetes ? YES NO
56. Has a doctor ever said you had kidney or bladder disease or infection ? YES NO
57. Has a doctor ever said you had liver disease ? YES NO
58. Do you have any numbness or tingling in any part of your body ? YES NO
59. Has any part of your body ever been paralyzed ? YES NO
60. Do you ever have fits or convulsions ?
61. Do you have a tendency to faint ? YES NO
62. Do you have frequent severe headaches ? YES NO
63. Do you consider yourself to be a nervous person ? YES NO
64. Do you suffer from severe nervous exhaustion ? YES NO
65. Do you often feel unhappy and depressed ? YES NO
66. Do you often cry ? YES NO
67. Are you easily upset or irritated ? YES NO
68. Women - Are you taking female hormones (oral contraceptives, etc.) ? YES NO
69. Women - Are you pregnant at the present time ? YES NO
70. Women - Are you in or have you passed through the menopause (change of life) ? YES NO
71. Women - Have you had a hysterectomy or ovariectomy ? YES NO

Please inform the doctor if your health changes in any way.

Signature _____