# Medical Questionnaire

We are aiming to provide best treatment for patients as possible. It would be great if you answer this medical questionnaire for understanding your systematic and oral health.

| | |
|---|---|
| **Name** | **Date** (  .  .  .)<br>**Date of Birth** (  .  .  .)<br>**Sex** Male ／ Female **Age** (  ) years old |
| **Address** 〒 | **phone** (  ) — (  ) — (  )<br>**e-mail** (  @  ) |
| | **Nationality** (  ) |
| | **Language** (  ) |
| | **Occupation** (  ) |
| **Convenient Day & Time** | **Mon/Tue/Wed/Thu/Fri/Sat** (  :  , **AM / PM** ) |

**✤What is the trouble or problem? (multiple choices allowed)**

- ❑ tooth hurts
- ❑ sensitive tooth
- ❑ tooth chipping
- ❑ pain/swelling of gum
- ❑ bleeding at brushing
- ❑ occlusal problem
- ❑ esthetic problem
- ❑ whitening
- ❑ problem of dentition
- ❑ dental implants
- ❑ dentures
- ❑ second opinion
- ❑ check up
- ❑ cleaning
- ❑ wisdom teeth
- ❑ desorption of filling （Do you have the filling？ yes / no）
- ❑ others (  )

**✤When did the trouble occur?** (  ) ( days・months・years ) ago

**✤Which area is your trouble？**

- ❑ back of upper right
- ❑ front of upper right
- ❑ front of upper left
- ❑ back of upper left
- ❑ back of lower right
- ❑ front of lower right
- ❑ front of lower left
- ❑ back of lower left

**✤When is the last dental treatment？** (  ) ( days・months・years ) ago

**✤Have you have any trouble at treatment or local anesthesia ever？**

❑ No ❑ Yes ( if yes, please check the following symptoms )

- ❑ felt sick
- ❑ anesthesia did not work
- ❑ Blood was hard to stop
- ❑ others (  )

**✤Do you have systematic problem?**

❑ No ❑ Yes ( if yes, please check the following symptoms )

- ❑ Hypertension
- ❑ Osteoporosis
- ❑ Diabetes
- ❑ Asthma
- ❑ Heart disease
- ❑ Cerebrovascular disorder
- ❑ Hepatitis ( A / B / C )
- ❑ Orthers (  )

**✤Are you taking any other medicine at the moment?**

❑ No ❑ Yes ( if yes, please check the following symptoms )

- ❑ Names of medicine (  ) (  )

**Please also fill in the back side**

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**✤Do you have allergy?**

❑No ❑Yes ( if yes, please check the following symptoms )

❑hay fever ❑drugs (  )
❑foods (  ) ❑others (  )

**✤Do or have you smoke?**

❑No
❑Stoped（had smoked for (  ) years, stoped at (  ) years ago
❑Smoking →How many per day? (about  )
❑e-cigarette →How many per day? (about  )

**For Female**

**✤Are you pregnant?**

❑No ❑Yes（ months） ❑Maybe

**✤Are you breastfeeding**

❑No ❑Yes

**✤Please give priority to 3rd from the list.**

(  ) Short Treatment period
(  ) High Quality and Prolongation
(  ) Low Treatment Fee
(  ) Good Esthetics
(  ) Strength
(  ) Others（  ）

**✤Please tell me your demand for treatment**

❑I want to be treated within insurance you covered
❑I want to be asked the treatment options at each step
❑I want to be treated with best solution on my main problem
❑I want to have consultation for ideal treatment on whole mouth. (Top-down Treatment Design®)
- ▸Top-down Treatment Design®) is always planned by Dr. Maruo
- ▸Though it will cost ¥10,000 as analysis fee, you will pay-off if you choose the planning.

**✤How do you know our clinic?**

❑Signboard → near by（ home ・ office ）
❑Website→（Official HP・EPARK・google MAP ・Others）
❑Introduction from other clinic →（  ）
❑Introduction from friends or family →（  ）

**✤Your Level of Japanese is....**

❑Not at all
❑Little bit
❑Daily Conversation

**✤Please note if you have any demand or request for treatment.**

THANK YOU FOR YOUR COOPERATION.

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