カルNo.

Name Male/Female Date of Birth / / Age

Address 〒

TEL

Please answer the following questions by ticking the correct box.

1, What is the reason for your visit today?(来院理由)

☐Cleaning ☐Check up ☐Tooth ache(歯痛) ☐Bleeding gums(出血) ☐Other

2, Are your teeth sensitive to any of the following: (歯に刺激を感じるもの)

☐Hot ☐Cold ☐Sweets ☐Biting/Chewing(噛んだ時)

3, Have you ever used anesthesia in dental treatment in the past? (歯科麻酔の使用歴)

☐Yes ☐No

＊ If Yes, did you have any allergic reaction? (歯科麻酔に対するアレルギー)

☐Yes ☐No

4, Do you smoke or use tabacco?(喫煙)

☐Yes ☐No

5, Do you suffer from allergies? (アレルギー)

☐Yes ☐No

＊ If Yes, please give details ----------

6, If you have had any of the following conditions, please place a tick on the box.

☐Asthma(喘息) ☐High blood pressure(高血圧) ☐Low blood pressure(貧血)
☐Heart disease(心臓疾患) ☐Heart attack(心臓発作) ☐Liver diease(肝臓病)
☐A,B or C hepatitis(肝炎) ☐Diabetes(糖尿病) ☐Epilepsy(てんかん)
☐HIV ☐Other ----------

7, Are you taking any medication?(服薬)

☐Yes ☐No

＊ If Yes, please give details ----------

8, Are you pregnant?(妊娠)

☐Yes ☐No