

It is very important to know your medical history and state of health. All information given here is strictly confidential.  
あなたの既往症と体調を事前に把握しておく事は大切な事です。個人情報の秘匿は守られます。

## General Patient Information 患者の情報

フリガナ:  
Last name 姓        First name(s) 名 \_\_\_\_\_

Male  男 Female  女  Occupation 職業 \_\_\_\_\_ Nationality 国籍 \_\_\_\_\_

Date of Birth 生年月日    Year:    Month: \_\_\_\_\_ Day: \_\_\_\_\_ Address in Japan 日本での住所 \_\_\_\_\_

Language(s) 言語 \_\_\_\_\_

Phone number 電話 \* \_\_\_\_\_

E-mail/fax メール・ファックス \_\_\_\_\_

## Chief Complaint(s) 主訴 If none, go to next section

Toothache 歯が痛い Please mark the problem area(s) 何所ですか

Cavity/hole in a tooth 虫歯

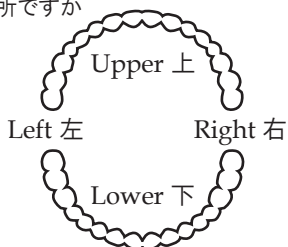
A filling/cap came out 詰め物、かぶせ物が取れた

A chipped tooth 歯が欠けた

A loose tooth 歯がぐらぐらする

Sensitive teeth 歯がしみる

Other (please write) 他 \_\_\_\_\_



Pain in jaw あごが痛い

Bleeding gums 歯肉出血

Swollen and painful gums 歯肉が腫れて痛い

Bad breath 口臭がある

Loose denture(s) 入れ歯がぐらつく

How long have you had this? どのくらい? \_\_\_\_\_ hour(s) 時間  day(s) 日間  week(s) 週間  month(s) ケ月 \_\_\_\_\_ year(s) 年間

## I wish to have... 以下の受診希望 If none, go to next section

My teeth cleaned 歯をクリーニングしたい

My denture(s) checked/fixed 入れ歯のチェック、治療

Plaque/tartar removed 歯垢を取りたい

New denture(s) 新しく入れ歯を作りたい

Other (please write) 他 \_\_\_\_\_

## Illness and Surgical History 既往歴、手術歴

Please select any illnesses you have had. 該当する疾患に印をつけて下さい

High blood pressure 高血圧  Kidney disease 腎臓病  Convulsions or Epilepsy けいれん・てんかん

Diabetes 糖尿病  Liver disease 肝臓病  Tuberculosis 結核

Heart disease 心疾患  Thyroid problems 甲状腺異常  Hepatitis B or C B/C型肝炎

Cerebrovascular disease 脳血管疾患  Asthma 喘息  HIV エイズ

Other (please write) 他 \_\_\_\_\_

Have you had any operations before? 手術歴  
No  Yes  What? 何の手術 \_\_\_\_\_

Have you had a blood transfusion? 輸血歴  
No  Yes  What was it for? 何の為 \_\_\_\_\_

Do you tend to bleed much? 出血傾向 No  Yes  Not sure  わからない

## Family History 家族歴

Please select any illnesses your immediate family have had. 親族での

High blood pressure 高血圧  Kidney disease 腎臓病  Cancer 癌

Diabetes 糖尿病  Liver disease 肝臓病  Hereditary diseases 遺伝子関連疾患

Other (please write) 他 \_\_\_\_\_

Go to REVERSE SIDE

## Allergies アレルギー

Have you ever been allergic to anything? (medicine, food, other) アレルギーの有無(薬、食べ物、他)

No  Yes  What? 何に

Have you had side effects caused by medicine? 薬の副作用の有無

No  Yes  Which medicine? 薬名

Have you had problems after having a local or general anesthetic? 全身又は局所麻酔歴

No  Yes  What? 何に

## Questions for Women 女性への質問

Are you pregnant? 妊娠していますか

No  Yes  Not sure  わからない

Are you currently breastfeeding? 今、授乳中ですか

No  Yes

Are you taking contraceptive pills? 今、避妊用のピルを服用していますか

No  Yes

## Medication 薬

Are you currently taking any prescribed or over-the-counter medicine(s)? 今、処方薬又は売薬を服用していますか

No  Yes  Which medicine(s)? 何の薬を

Bufferin  Aspirin  Warfarin ('Coumadin,' 'Warfilone,' 'Marevan')

Other: Please write the medicine name(s). 薬名を具体的に書いて下さい

Why are you taking it/them? 何の為

## Alcohol and Tobacco お酒とタバコ

Do you regularly drink alcohol? お酒を定期的に飲みますか

No  Yes  How much in 1 week? 週にどのくらい? →

1 beer (500ml)



× \_\_\_\_\_  
ビール500ml

1 glass of wine



× \_\_\_\_\_  
グラスワイン

1 measure  
of spirits



× \_\_\_\_\_  
リキュール

Other: その他

Do you smoke? タバコは吸いますか

No  Yes  How many a day? 一日に \_\_\_\_\_ 本 How long have you smoked? どのくらい \_\_\_\_\_ months ケ月間 \_\_\_\_\_ years 年間

Did you smoke before? 以前に吸ったことがありますか

No  Yes  How many a day? 一日に \_\_\_\_\_ 本 When did you stop? いつやめましたか \_\_\_\_\_ months ago ケ月前 \_\_\_\_\_ years ago 年前

## Treatment Preferences and Medical Fees 治療の希望と医療費

Do you have Japanese Health Insurance or private medical insurance? 日本の保険証又は他の私的医療保険証をお持ちですか

No  Yes  Do you only want treatment covered by the insurance? 保険を使える治療だけを希望しますか No  Yes  Not sure  わからない

Do you only want treatment for your main problem? 現在困っている問題の治療のみ希望しますか

No  Yes  Not sure  わからない

Please return this form. Thank you.