

PATIENT NAME _____

DATE _____

予約された主な理由は何ですか?

診察 緊急 相談

Primary reason for this dental appointment: Examination Emergency Consultation

Dental History

Please Circle

Do you have a specific dental problem? Describe... Do you have dental examinations on a routine basis? Last visit... Do you think you have active decay or gum disease? Do you brush and floss on a routine basis? Do your gums ever bleed? Do you like your smile? Why? Does food catch between your teeth? Any loose teeth? Do you want to keep your remaining teeth? Do you ever have clicking, popping or discomfort in the jaw joint? Do you brux or grind? Have your past experiences in a dental office always been positive? Do you smoke or chew? Any sores or growths in your mouth? Name of previous dentist (optional): Date of last full mouth x-rays (16 small films or panoramic):

Medical History

Are you under a physician's care now? Why? Have you ever been hospitalized or had a major operation? Have you ever had a serious injury to your head or neck? Are you taking any medications, pills or drugs? What? Are you on a special diet? Are you allergic to any medications or substances? Women (Please check): Pregnant/trying to get pregnant Nursing Taking oral contraceptives

Do you now have or have you ever had any of the following? Please check appropriate boxes. *If yes to any of the starred conditions, please call prior to your appointment... premedication may be required.

- 心臓疾患 打撲症が得意やすい 気腫 黄疸 寒気・悪寒
心雑音 貧血 結核 腎臓疾患 疱疹
不整脈 止血しにくい ガン 腎臓透析 ヘルペス
咽頭の炎症/胸痛 鎌状赤血球病 放射線治療 甲状腺疾患 脳卒中
心臓発作/機能障害 血友病 化学療法 副甲状腺疾患 マヒ
先天性心臓障害 白血病 胃腸疾患 関節炎/痛風 テンカン発作
心臓弁膜症 輸血 潰瘍 リウマチ めまい
しょうこう熱 手足のむくみ ダイエット 頸関節症 緑内障
リュウマチ熱 肺疾患 習慣性下痢 コーチゾン 腫瘍
心臓人工弁 呼吸疾患 糖尿病 人工関節 神経過敏
ペースメーカー 息切れ のどの渇き 性病 精神病
心臓手術 頻繁な咳 低血糖症 エイズ アルツハイマー
高血圧 枯草ゼンソク 肝臓疾患 HIV陽性 アレルギー(薬)
低血圧 鼻炎 A型肝炎 生殖器のヘルペス アレルギー(ホコリ/花粉)
血液疾患 ゼンソク B・C型肝炎 麻薬常用者 湿疹

今まで、上記以外の重病にかかったことはありませんか?

Do you wish to talk to the dentist privately about any problem? 何か個人的に歯科医と話したいことがありますか? Yes No

To the best of my knowledge, all the preceding answers are correct. If I have any changes in my health status or if my medicines change, I shall inform the dentist and staff at the next appointment without fail.

PATIENT SIGNATURE (PARENT OR GUARDIAN) 患者のサイン(両親または保護者) Date

Reviewed By Doctor _____ Date _____ BP _____

History Review and Significant Findings _____

Medical Updates

I have read my MEDICAL HISTORY dated _____ and confirm that it adequately states past and present conditions.

Table with columns: DATE, EXCEPTIONS, PATIENT'S SIGNATURE, BP, REVIEWED BY. Includes rows for None and Dr. signatures.