Consultation application form

Name : (First) (Last) Sex : M ・ F

Address : Date of birth : / / M D Y

Phone : (home) — — Cellular phone : (or office No.) — —

☆☆☆ Individual information on you is never used for purposes other than the diagnosis and treatment for you.
And it goes without saying that we will never inform others of that. Clinic director NITTA TOMOHIRO D.D.S.

Dental Health Questionnaire

My Chief Complaint or Reason for this Examination is:

HAVE YOU EVER HAD OR HAVE YOU NOW : (Please check at the right of each item)

	Yes	No	Don't Know		Yes	No	Don't Know		Yes	No	Don't Know
Epileptic seizure				Hemophilia				Ulcers			
Fainting or Dizziness				Bruise or bleed easily				Kidney problems			
Nervousness				Heart Problems or Angina				Venereal disease			
Stroke				Hypertension				Diabetes			
Glaucoma				Rheumatic fever				Thyroid disease			
Cold sores (Herpes)				Heart murmur				HIV			
Persistent cough				Mitral valve prolapse				Arthritis			
Emphysema				Congenital heart lesions				Painful joints (incl. jaw)			
Tuberculosis/PPD positive				Heart surgery				Prosthetic joint(s)			
Asthema				Prosthetic heart valve(s)				Hives			
Hay Fever				Pacemaker				Steroid medication(s)			
Sinus problems				Blood transfusion(s)				Drug addiction			
Anemia				Liver disease				Alcoholism			
Sickle cell disease				Yellow jaundice				Unexplained weight change			
G-6PD deficiency				Hepatitis-type				Cancer/radiation			

	Yes	No
1.Have you ever been told that you should not donate blood?	☐	☐
2.Have you ever been told that you need antibiotics before dental treatment?	☐	☐
3.Females : Are you taking birth control pills (BCPs)?	☐	☐
⇨Are you or might you be pregnant?(Estimated delivery)	☐	☐
⇨Are you breast feeding at the present time?	☐	☐

4.Do you have a disease,condition,or problem not listed above?

⇨If yes, please describe : _____

5.Are you taking any tablets, pills, medications, drugs? ☐ ☐

⇨If yes, please list : _____

_____

_____

Signature : _____ **Date :** / / M D Y

NITTA DENTAL CLINIC