Date (y)/ (m)/ (d)

Questionnaire

Name Sex M / F

Date of birth Year/ Month/ Day (Years old)

Address 〒

Phone Nationality

Name of work place or school (TEL)

What is the problem today?

When did the symptom start?

Do you have any food or medication allergies?

☐No ☐Yes ( )

What illness have you had in the past?

Are you currently attending another hospital?

☐No ☐Yes ( )

Have you ever felt sick from dental anesthesia? ☐No ☐Yes

Are you pregnant or is there a possibility of pregnancy?

☐No ☐Yes (weeks)

I'd like to ask you about your menstrual periods. ☐No problem ☐Irregular ☐Menopause

Would you like to receive DMs from our clinic? ☐No ☐Yes

How did you find out about our clinic? ☐Internet ☐Signboard

☐Magazine ( ) ☐Introduction ( ) ☐Others ( )