New patients 1 / 2 — Today's visit

Patient questionnaire

Answer what you can. If you're not sure, leave it blank and ask at reception.

Date / /

Clinic name (stamp)

1 About you

Name
in capital letters

Name
in katakana, if known

Date of birth Year Month Day

Sex ☐ Male ☐ Female ☐ Prefer not to say

Phone
daytime number

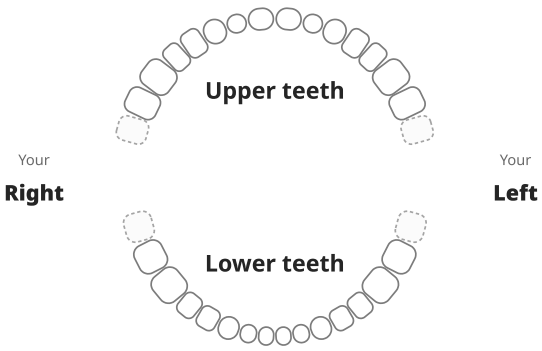
Address 〒

Language
you prefer

2 What brings you in today? Tick all that apply

- ☐ Toothache
- ☐ Lost filling or crown
- ☐ Wisdom tooth
- ☐ Bad breath
- ☐ Sensitive teeth
- ☐ Chipped or broken tooth
- ☐ Jaw pain or can't open wide
- ☐ Tooth color or alignment
- ☐ Bleeding or swollen gums
- ☐ Denture doesn't fit or is broken
- ☐ Lump or sore in the mouth
- ☐ Check-up or cleaning
- ☐ Other _____

3 Where is the problem, and since when?



Circle where the problem is (dotted = wisdom teeth). The chart shows your mouth as someone facing you sees it.

☐ Not sure where ☐ Whole mouth

Since when

- ☐ Today
- ☐ 2–3 days ago
- ☐ 1–2 weeks ago
- ☐ Over a month ago
- ☐ On and off for a while

How bad is the pain? At its worst. Circle a number

0 1 2 3 4 5 6 7 8 9 10

No pain — Worst pain imaginable

Painkillers

- ☐ Not taken
- ☐ Taken (name _____)

4 Your wishes Leave blank if you haven't decided

What to check ☐ Only the problem area ☐ My whole mouth

Explanations ☐ In detail ☐ Just the key points

Treatment ☐ Covered by health insurance ☐ Also tell me about options not covered

Best days Days _____ Times _____

Last dental visit ☐ Within 6 months ☐ Within a year ☐ Several years ago ☐ Can't remember

Form by a practising dentist (Zubora Ha Lab, Japan) · November 2026 edition
Free to use; terms of use: zubora-lab.com/sheets/ (Japanese)

Please fill in the back too →

New patients 2 / 2 — Your health

About your health

This helps us treat you safely.

Name

5 Current or past medical conditions

Tick all that apply

☐ None

☐ High blood pressure
☐ Heart disease (angina, heart attack, heart failure, irregular heartbeat)
☐ Heart valve disease, artificial valve, or past endocarditis
☐ Pacemaker or implanted defibrillator
☐ Stroke
☐ Diabetes (HbA1c _____ %)
☐ Asthma
☐ Liver disease (e.g. hepatitis)
☐ Kidney disease (incl. dialysis)
☐ Osteoporosis
☐ Cancer (now or in the past)
☐ **Head or neck radiation therapy** (mouth, throat, nose, etc.) (year _____)
☐ Bleeding disorder (e.g. hemophilia)
☐ Epilepsy
☐ Thyroid disease
☐ Rheumatoid arthritis or connective tissue disease
☐ Anemia
☐ Stomach or duodenal ulcer

Other conditions _____

Your doctor / hospital _____

6 Medicines you take

☐ None ☐ Yes → please show your medicine record or list at reception

We always check these before treatment such as extractions. Tick any that apply.

☐ **Blood thinners**
e.g. warfarin, aspirin, clopidogrel, apixaban, rivaroxaban, edoxaban

☐ **Bone medicines** (for osteoporosis, or cancer affecting the bones; tablets, injections or drips, including weekly, monthly or 6-monthly)
e.g. alendronate, risedronate, minodronate, ibandronate, denosumab (Prolia, Xgeva), zoledronic acid

☐ **Steroids or immunosuppressants** ☐ **Diabetes medicines or insulin** ☐ Other _____

7 Allergies and anesthesia

Allergies ☐ None ☐ Medicine (name _____) ☐ Dental anesthetic ☐ Metal ☐ Latex (rubber) ☐ Food (_____) ☐ Other (_____)

Felt unwell with dental anesthesia or treatment? ☐ No ☐ Yes (when _____)

8 Pregnancy, breastfeeding

☐ No ☐ Pregnant (_____ weeks)
☐ Possibly pregnant ☐ Breastfeeding

9 Smoking

Including heated tobacco

☐ No ☐ Yes (_____ a day)
☐ Quit (_____ years ago)

10 What you find hard at the dentist

Tell us and we can talk about it first

☐ Nothing

☐ Drilling noise ☐ Smells ☐ Keeping my mouth open ☐ Gagging easily
☐ Injections (anesthetic) ☐ Pain ☐ Lying back ☐ A bad past experience

11 Anything else you'd like us to know

_____

_____

For clinic use		
Checked	Reception	Notes

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