INTERVIEW SHEET

初診年月日　DATE

	SEX	AGE	DATE OF BIRTH
NAME	**Male/Female**	**(　)**	**(　/　/　)**
RESIDENCE ADDRESS			
RESIDENCE TEL	**HANDY PHONE**		
OCCUPATION	**NAME OF COMPANY**		
Insurance	**How did you know this clinic?**		

1) How may I help you?

2) About pain.　What`s sort?　When does it hurt?　From when?

3)Have you ever been given anesthesia? .....Yes ・ No
　Was there probrem?　Yes・No
Have a extracted teeth?
　Was there probrem?　Yes・No

4）Do you　have allergic?　　Yes・No
　Are you pregnant?　Yes・No
　Drug Reaction?　Yes・No?　（Drug Name/Reaction :　　）

5) CURRENT MEDICATION ?　Yes・No　（Name　　）

6)Do you have any medical problems?
(

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7)Did you have any medical problems in the past?

・ALLERGY　　・ANEMIA　　・HEART TROUBLE
・DIABETES　　・HEPATITIS　　・HIGH BLOOD PRESSURE
・ASTHMA　　・NEPHRITIS　　・RHEUMATISM
・OTHERS（　　）

8)Other do you have?