

## Pre examination

Year \_\_\_\_\_ month \_\_\_\_\_ day \_\_\_\_\_

Name \_\_\_\_\_ Office Name \_\_\_\_\_

Date of Birth \_\_\_\_\_ Office Tel \_\_\_\_\_

Add\_〒 \_\_\_\_\_

Tel \_\_\_\_\_ Occupation \_\_\_\_\_

- ① Have you ever been here before? No, Yes, \_\_\_\_\_ for how many times.
- ② What is the matter with you?
- ③ Recent Health condition. Are you pregnant?  
Yes, How many monthes \_\_\_\_  
No.
- ④ Are you suffering from the following diseases or have you ever have this following diseases?  
A) Liver diseases C) Heart disease  
B) High or Low Blood pressure. D) Kidney disease  
E) Others, Please specify \_\_\_\_\_
- ⑤ Are you now under treatment? No.  
Yes, Disease \_\_\_\_\_  
Hospital \_\_\_\_\_
- ⑥ Are you taking any medicine? \_\_\_\_\_
- ⑦ Are you allergic to the following:  
A) Local anesthesia  
B) Antibiotics  
C) Others \_\_\_\_\_
- ⑧ Have you felt sick when you are injected a local anesthesia?  
( \_\_\_\_\_ )