

NDO QUESTIONNAIRE

Date / /

Please fill in all blank.

First Name _____ Family Name _____

Sex _____ Male _____ Female _____ Birthday (Age) _____ ()

Nationality _____ Occupation _____

Home Address _____

Home Telephone No. _____ Mobile Phone No. _____

Email address _____ @ _____

You are a (permanent resident / temporary resident (until / /) / traveller)

Do you have a Japanese National Health Insurance? (Yes / No)

Which language do you prefer to communicate in? (English / Japanese / Neither)

How did you know about our dental office?

どのようにして当院を知りましたか？

What is the matter with you today?

今日はどうされましたか？

When was your last dental visit?

最後に歯科を受診されたのはいつですか？

What was your last dental visit?

最後に歯科を受診した際、何をしましたか？

Do you have pain? NO YES → Please fill another "NDO Pain Questionnaire"

痛みはありますか？

Are you taking any medicine?

薬を飲んでいませんか？

Do you have allergy to any medications or dentophobia?

薬のアレルギーや歯科恐怖症はありますか？

Do you have any systemic disease ?

全身的な病気はありますか？

Do you have any other present illness?

今、他に何か病気にかかっていますか？

If you have had infectious disease before, please describe it.

過去に感染症にかかったことはありますか？

Do you have any request for the Dr?

何か、ドクターにリクエストはありますか？

Oral Health Impact Profile (OHIP-14)

1. Have you had trouble pronouncing any words because of problems with your teeth, mouth or denture?	<u>Never</u>	<u>Hardly ever</u>	<u>Occasionally</u>	<u>Fairy often</u>	<u>Very often</u>
2. Have you felt your sense of your taste has worsened because of problems with your teeth, mouth or denture?	<u>Never</u>	<u>Hardly ever</u>	<u>Occasionally</u>	<u>Fairy often</u>	<u>Very often</u>
3. Have you had painful aching in your mouth?					
4. Have you found it uncomfortable to eat any foods because of problems with your teeth, mouth or denture?	<u>Never</u>	<u>Hardly ever</u>	<u>Occasionally</u>	<u>Fairy often</u>	<u>Very often</u>
5. Have you been self conscious because of your teeth, mouth or denture?	<u>Never</u>	<u>Hardly ever</u>	<u>Occasionally</u>	<u>Fairy often</u>	<u>Very often</u>
6. Have you felt tense because of problems with your teeth, mouth or denture?	<u>Never</u>	<u>Hardly ever</u>	<u>Occasionally</u>	<u>Fairy often</u>	<u>Very often</u>
7. Has your diet been unsatisfactory because of problems with your teeth, mouth or dentures?	<u>Never</u>	<u>Hardly ever</u>	<u>Occasionally</u>	<u>Fairy often</u>	<u>Very often</u>
8. Have you had interrupt meals because of problems with your teeth, mouth or dentures?	<u>Never</u>	<u>Hardly ever</u>	<u>Occasionally</u>	<u>Fairy often</u>	<u>Very often</u>
9. Have you found it difficult to relax because of problems with your teeth, mouth or dentures?	<u>Never</u>	<u>Hardly ever</u>	<u>Occasionally</u>	<u>Fairy often</u>	<u>Very often</u>
10. Have you been a bit embarrassed because of problems with your teeth, mouth or dentures?	<u>Never</u>	<u>Hardly ever</u>	<u>Occasionally</u>	<u>Fairy often</u>	<u>Very often</u>
11. Have you been a bit irritable with other people because of problems with your teeth, mouth or dentures?	<u>Never</u>	<u>Hardly ever</u>	<u>Occasionally</u>	<u>Fairy often</u>	<u>Very often</u>
12. Have you had difficulty doing your usual jobs because of problems with your teeth, mouth or dentures?	<u>Never</u>	<u>Hardly ever</u>	<u>Occasionally</u>	<u>Fairy often</u>	<u>Very often</u>
13. Have you felt that life in general was less satisfying because of problems with your teeth, mouth or dentures?	<u>Never</u>	<u>Hardly ever</u>	<u>Occasionally</u>	<u>Fairy often</u>	<u>Very often</u>
14. Have you been totally unable to function because of problems with your teeth, mouth or dentures?	<u>Never</u>	<u>Hardly ever</u>	<u>Occasionally</u>	<u>Fairy often</u>	<u>Very often</u>

NDO Pain Questionnaire

The following questions are to inquire about the pain you are currently experiencing. In situations where more than one type of pain are experienced, please fill out an additional questionnaire.

1. Site of pain: Where are you experiencing the pain? (Please circle the choices below.) 痛む場所は? right / left / upper / lower / tooth / gums / tongue / face / temple / head / neck / etc
2. Manifestation of pain: What causes the onset of the pain? 痛みのきっかけは? no noticeable cause / yawning / eating hard foods / dental treatment / injury / hectic lifestyle stress / etc
3. Period of time the pain has been experienced: How long have you been experiencing this pain? 痛くなった時期 Approximately _____ years; _____ months; _____ weeks; _____ days
4. Type of pain: Would the pain be best described as which of the following? 痛みの種類は? throbbing / sudden sharp running / piercing / sharp / similar to an electrical shock / dull / gripping / cutting / burning / stinging / slightly chafing / tingling / intense / sensitive to touch breaking sensation / persistent / nauseating / frightening / unbearable and excruciating
5. Severity of pain a: low / moderate / strong / severe b: How would the pain be rated on a scale of 1 to 10? 【min】 1 / 2 / 3 / 4 / 5 / 6 / 7 / 8 / 9 / 10 【max】 c: Which of the following is appropriate for the pain being experienced? simply noticeable / causes difficulty working / causes inability to work not noticeable when eating / able to eat despite pain / causes inability to eat
6. Frequency of pain: How often does the pain occur? 痛みの頻度は? _____ times a month / week / day / hour / minute or constant pain
7. Duration of pain: How long does the pain last each time it is experienced? 痛みの持続 _____ days / hours / minutes / seconds or constant pain
8. Distinctive features of the pain throughout the day: Is there anything to note of the pain in regard to time of day? 痛くなるときはいつ? When rising from sleep, the pain is light / strong During the day, the pain is light / strong During the evening and at night, the pain is light / strong During sleep, the pain is light / strong
9. Do any of the following cause the pain to occur or become more severe? 痛みを悪化させるのはどんなとき? eating / physical activity / work / bathing / sleeping / anxiety / stress
10. Do any of the following help alleviate the pain? 痛みを軽くするには? applying a cold compress / applying heat / rest / sleep / massage / pain medication
11. Accessory symptoms: Do any of the following symptoms occur when experiencing the pain? 痛みとともに出る症状 headache / stiff shoulder / dizziness / numbness / tearing of eyes / runny nose / tightness in chest / irritation of eyes / nausea / vomiting
12. Behavior during pain: Are any of the following regularly done or experienced when the pain occurs? 痛みを緩和する方法は? inability to be still / lying down / rubbing / pressing / moving as little as possible

If you have any requests, please write it below.