NDO QUESTIONNAIRE

Date / /

Please fill in all blank.

First Name _____ Family Name _____

Sex Male Female Birthday (Age) _____ ( )

Nationality _____ Occupation _____

Home Address _____

Japanese Phone No. _____

Email address _____ @ _____

Mother tongue _____ Second language _____

How long do you stay in Kyoto from today(or current adress) (2years ↑ / 2years ↓ ( )month / traveller)

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

Which language do you prefer to communicate in? (English / Japanese / Others)

Can you get medical terms in Japanese or English? (Yes / Have worries)

What kind of treatment would you like to choose? (Insurance / Private / Not decided)

How did you know about our dental office? If you have introducer, please give him / her name.
どのようにして当院を知りましたか？紹介者がいる場合は、差し支えなければお名前を記載ください。

_____

What is the matter with you today?
今日はどうされましたか？

_____

_____

When was your last dental visit? And then what was it?
最後に歯科を受診されたのはいつですか？その際何をしましたか？

_____

Do you have pain / sensitivity? ☐ NO ☐YES → Please fill another "NDO Pain Questionnaire"
痛みやしみるのはありますか？

Are you taking any medicine?
薬を飲んでいますか？ _____

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

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.