Forms for ages 75 and older

FY2025 Checkup Sheet for "Oral Health Checkup"

R7

(Residents who were born before March 31, 1950)

This Checkup Sheet is valid for the following periods:First half of the year:June 1, 2025 to August 31, 2025.
Second half of the year:November 1, 2025 to January 31, 2026.

Date	Year:____ / Month:____ /Day:____		
Name in Kana syllabary		**Sex**	
Name		Male / Female	Address:
Date of Birth	Year:____ / Month:____ /Day:____	**Age:**	Tel:

Please fill in the required items in the above box and then answer the following questions before the start of your dental checkup. Please circle the applicable answers.

Home visit

Questions about your oral health/habits (to be filled in by the patient)

Have you ever had the "Oral Health Checkup" in Minato City before? Yes No

Q1: Oral matters you are worried about

1-1: Do you currently have any pain or anything else that concerns you in your teeth, gums or the joints of your jaw, etc?	Yes		No
1-2: Is there any bleeding when you brush your teeth?	Yes	Sometimes	No
1-3: Do any teeth seem loose?	Yes	Sometimes	No

Q2: Your daily healthcare habits

2-1: Do you brush your teeth at night before going to bed?	No	Sometimes	Most Days
2-2: Do you use interdental brushes or dental floss, etc. (interdental cleaning aids)?	No	Sometimes	Most Days
2-3: Do you ever examine your teeth, gums or tongue carefully using a mirror?	No	Sometimes	Most Days
2-4: Do you take your time to eat and chew your food well?	No	Sometimes	Most Days
2-5: Do you get out of the house often?	No		Yes
2-6: Do you get enough rest?	No		Yes
2-7: Do you eat breakfast?	No	Sometimes	Yes
2-8: Do you snack (sweet foods and drinks)?	Most days	Sometimes	No
2-9: Do you drink alcohol?	Most days	Sometimes	No
2-10: Do you smoke? (including heated tobacco)	Yes(20 or more cigarettes a day)	Yes(19 or fewer cigarettes)	No
2-11: How many types of orally administered medication do you take per day?	5 types or more	1–4 types	None

Q3: Visiting a dental clinic

3-1: Do you have a family dentist?	No		Yes
3-2: Do you have regular dental checkups once a year or more?	No		Yes
3-3: Have you had tartar removed within the last six months?	No		Yes

Q4: About your oral health in general

4-1: Are you able to enjoy your food?	No		Yes
4-2: Do you find it difficult to eat hard food compared to six months ago?	Yes		No
4-3: Do you sometimes choke on your tea or soup?	Yes		No
4-4: Are you concerned about cotton mouth?	Yes		No

(Please answer Q4-5 after completing the chewing gum test)

4-5: When you chewed on the gum, did you feel any pain or looseness in your teeth?	Yes	No

Q5: If there is anything else you are concerned about, please describe it in the following box.