

FY2026 Checkup Sheet for “Oral Health Checkup”

R8

(Residents who were born before March 31, 1951)

This Checkup Sheet is valid for the following periods: First half of the year: June 1, 2026 to August 31, 2026.
Second half of the year: November 1, 2026 to January 31, 2027.

Date	Year: ____ / Month: ____ / Day: ____			
Name in Kana syllabary			Sex	
Name			Male	Female
Date of Birth	Year: ____ / Month: ____ / Day: ____		Age:	
			Address:	
			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
1-3: Do any teeth seem loose?	Yes	Sometimes
Q2: Your daily healthcare habits		
2-1: Do you brush your teeth at night before going to bed?	No	Sometimes
2-2: Do you use interdental brushes or dental floss, etc. (interdental cleaning aids)?	No	Sometimes
2-3: Do you ever examine your teeth, gums or tongue carefully using a mirror?	No	Sometimes
2-4: Do you take your time to eat and chew your food well?	No	Sometimes
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
2-8: Do you snack (sweet foods and drinks)?	Most days	Sometimes
2-9: Do you drink alcohol?	Most days	Sometimes
2-10: Do you smoke? (including heated tobacco)	Yes(20 or more cigarettes a day)	Yes(19 or fewer cigarettes)
2-11: How many types of orally administered medication do you take per day?	5 types or more	1-4 types
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.		