

General Oral Examination Check List

<u>Name of examinee</u>			<u>Residence</u>	
<u>Resident Registration Number</u>		<u>Phone no.</u>	<u>Cellphone</u>	



(Dental) medical history and symptoms

1. Have you ever received an oral examination or visited a dental clinic for preventative/management purposes in the past year?
 ① Yes ② No
2. Do you currently have diabetes?
 ① Yes ② No ③ Don't know
3. Are you currently experiencing cardiovascular health problems?
 (ex: hypertension, hyperlipidemia, arteriosclerosis, etc.)
 ① Yes ② No ③ Don't know
4. Have you experienced sore teeth or throbbing pain in the last 3 months?
 ① Yes ② No
5. Have you experienced soreness or bleeding in your gums in the past 3 months?
 ① Yes ② No



Oral health quality of life and perception

6. In the last 3 months, have you had any difficulty in chewing food due to issues with your teeth or mouth, or because of your dentures?
 ① Yes ② No
7. When you think about your teeth and gums, how would you describe the overall condition of your oral health?
 ① Very good ② Good ③ Normal
 ④ Bad ⑤ Very bad



Oral hygiene management

9. In the last week, on average, how many times did you brush your teeth per day?
 An average of () times per day
10. During the past week, how often did you brush your teeth before going to bed?
 ① Always (7 times) ② Almost always (4-6 times)
 ③ Sometimes (1-3 times) ④ Never (0 times)
11. During the last 7 days, how often did you use floss or interdental brushes when brushing your teeth?
 ① Always
 ② Almost always
 ③ Sometimes
 ④ Never
 ⑤ Don't know what dental floss or interdental brushes are



Fluoride use

12. Does the toothpaste you currently use contain fluoride?
 ① Yes ② No
 ③ Don't know ④ Don't use toothpaste



Eating habits

Smoking

8. Do you smoke?

- ① Have never smoked ② Currently smoking
③ Previously smoked, now smoke-free

13. How often do you eat sweet or sticky snacks such as cookies, candies, and cakes per day?

- ① Never ② Once ③ Twice
④ 3 times ⑤ More than 4 times

14. How often do you drink fruit juice or drinks with added sugar

- (ex: soft drinks, sports drinks, etc.)?
① Never ② Once ③ Twice
④ 3 times ⑤ More than 4 times



Please write any special symptoms or questions you would like to ask your dentist.