David B. Krill, D.M.D., Inc.
David B. Krill, D.M.D.

Periodontics and Oral Diagnosis

8221 Cornell Road
Cincinnati, Ohio 45249

LAST NAME | FIRST NAME | MIDDLE | BIRTH DATE Mo.-Day-Yr. | HEIGHT | WEIGHT | MARITAL STATUS

NAME YOU WOULD LIKE TO BE CALLED | PATIENT SOCIAL SECURITY #

RESIDENCE ADDRESS | CITY | STATE | ZIP | RESIDENCE TELEPHONE | CELL TELEPHONE

EMPLOYER | ADDRESS | CITY | STATE | ZIP | BUSINESS TELEPHONE

NAME OF HUSBAND, WIFE OR PARENT | D.O.B. | DENTAL INSURANCE CARRIER | INSURED SOCIAL SECURITY #

REFERRED BY | NAME OF PHYSICIAN | TELEPHONE

GENERAL

		Circle One		*
1)	Has there been any change in your general health during the last year?	Yes	No	DK
2)	Have you been examined by your physician within the last year?	Yes	No	DK
3)	Are you receiving any treatment by any doctor now?	Yes	No	DK
4)	Are you taking any medicines now?	Yes	No	DK
5)	Have you taken or are you currently taking any medication for bone cancer or osteoporosis?	Yes	No	DK
6)	Have you ever had an operation?	Yes	No	DK
7)	Have you ever had a serious illness?	Yes	No	DK
8)	Have you ever been hospitalized?	Yes	No	DK
9)	Has a dentist or physician ever told you that you had a tumor or a cancer?	Yes	No	DK
10)	Have you ever had x-ray treatments?	Yes	No	DK
11)	Have you had rheumatic fever, rheumatic heart disease, growing pains, or twitching of the limbs?	Yes	No	DK
12)	Have you had a stroke (apoplexy, CVA)?	Yes	No	DK
13)	Have you ever had excessive bleeding following extraction of teeth or from a cut?	Yes	No	DK
14)	Are you allergic or sensitive to any particular medicine (Aspirin - Penicillin)?	Yes	No	DK
15)	Have you ever had an anesthetic? Local? Yes No General? Yes No	Yes	No	DK
16)	Have you ever been told not to take novocaine?	Yes	No	DK
17)	Do you suffer badly from frequent severe headaches?	Yes	No	DK
18)	Do you have spells of dizziness?	Yes	No	DK
19)	Have you fainted more than twice in your life?	Yes	No	DK
20)	Have you ever had severe pains of the face or head?	Yes	No	DK
21)	Have you ever been treated for eye trouble other than corrective glasses?	Yes	No	DK
22)	Have you ever been treated for ear trouble?	Yes	No	DK
23)	Do you have hay fever?	Yes	No	DK
24)	Do you have sinus trouble?	Yes	No	DK
25)	Have you at times had bad nose bleeds?	Yes	No	DK
26)	Do you have frequent sore throats?	Yes	No	DK
27)	Are you or have you ever been addicted to any medications, substances or alcohol?	Yes	No	DK
28)	Have you ever been diagnosed HIV positive?	Yes	No	DK

CARDIOVASCULAR

29)	Has a physician ever said you had heart trouble?	Yes	No	DK
30)	Have you ever had rheumatic heart disease? or Saint Vitus' dance?	Yes Yes	No No	DK DK
31)	Have you ever had a heart attack?	Yes	No	DK
32)	Has a physician ever said your blood pressure was too high or too low?	Yes	No	DK
33)	Do you get out of breath easily?	Yes	No	DK
34)	Are your ankles often badly swollen?	Yes	No	DK
35)	Do you bruise easily?	Yes	No	DK
36)	Do you have a heart murmur?	Yes	No	DK

GASTRO-INTESTINAL

37)	Do you suffer from stomach trouble?	Yes	No	DK
38)	Have you ever had liver trouble?	Yes	No	DK
39)	Do you have frequent diarrhea?	Yes	No	DK
40)	Has a physician ever told you that you had ulcers?	Yes	No	DK
41)	Are there any foods you cannot eat?	Yes	No	DK
42)	Have you gained or lost weight recently?	Yes	No	DK
43)	Have you ever been jaundiced?	Yes	No	DK
44)	Have you ever had hepatitis?	Yes	No	DK

RESPIRATORY

		Circle One *		
45)	Have you ever coughed up blood?	Yes	No	DK
46)	Do you have asthma?	Yes	No	DK
47)	Have you ever had tuberculosis?	Yes	No	DK
48)	Have you ever lived with anyone who had TB?	Yes	No	DK

GENITO-URINARY

49)	Are you thirsty much of the time?	Yes	No	DK
50)	Did a physician ever say that you had kidney or bladder trouble?	Yes	No	DK
51)	Do you have to get up every night to urinate?	Yes	No	DK
52)	Have you ever had syphilis?	Yes	No	DK

FEMALE

53)	Are you currently pregnant?	Yes	No	DK
	Number of pregnancies.....			
	Number of children.....			
54)	Is your menstrual cycle irregular?	Yes	No	DK
55)	Have you reached the menopause? (Change of life)	Yes	No	DK

ENDOCRINE SYSTEM

56)	Have you ever had diabetes?	Yes	No	DK
57)	Has a member of your family had diabetes?	Yes	No	DK
58)	Have you ever taken thyroid tablets?	Yes	No	DK
59)	Do you get tired easily?	Yes	No	DK

NERVOUS SYSTEM

60)	Have you ever had a nervous breakdown?	Yes	No	DK
61)	Has a physician ever told you that you had epilepsy?	Yes	No	DK
62)	Do you consider yourself a nervous person?	Yes	No	DK

SKIN

63)	Have you ever been treated for a skin disease?	Yes	No	DK
64)	Do cuts on your skin usually stay open a long time?	Yes	No	DK
65)	Have you ever had hives or skin rash?	Yes	No	DK

BONES AND JOINTS

66)	Are your joints often painfully swollen?	Yes	No	DK
67)	Have you ever had more than one fracture?	Yes	No	DK
68)	Have you ever had more than one dislocation?	Yes	No	DK
69)	Do you have arthritis or rheumatism?	Yes	No	DK
70)	Do you have any artificial prosthetic joints?	Yes	No	DK

DENTAL

71)	Do your gums bleed when you brush your teeth?	Yes	No	DK
72)	Have you ever had gum treatments?	Yes	No	DK
73)	Have you ever had an acute sore mouth?	Yes	No	DK
74)	Do your teeth ever feel sore when you bite on them?	Yes	No	DK
75)	Do any teeth feel high or long when you bite on them?	Yes	No	DK
76)	Do your jaws feel tired at the end of the day?	Yes	No	DK
77)	Do your jaws feel tired when you awaken in the morning?	Yes	No	DK
78)	Do you think your teeth are moving or drifting?	Yes	No	DK
79)	Do you grind or clinch your teeth when you are nervous or while sleeping?	Yes	No	DK
80)	Do your jaws crackle or pop when you yawn or open your mouth?	Yes	No	DK
81)	Do you feel that an attempt to save your teeth is a waste of time?	Yes	No	DK

Patient's Signature:_____ Date:_____

Chief Complaint:

Medical Summary: ☐ **NON CONTRIBUTORY** ☐ **SIGNIFICANT**

Patient's Name

*** DK = Don't Know**