Loop Perio

PERIODONTICS & IMPLANTS

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Today's Date _____

Birth Date _____

Patient's Name – Ms., Mrs., Mr. or Dr. _____

Marital Status – ____ Single ____ Married Email Address _____

Home Phone _____ Business Phone _____ Cell Phone _____

Preferred Methods of Contact (Please check all that apply): ☐Home # ☐Work # ☐Cell # ☐Cell Text ☐Email

Home Address _____

City _____ State _____ Zip code _____

Business Name _____

Business Address _____

City _____ State _____ Zip code _____

Dental Insurance Carrier & Address _____

Group Number _____ Subscriber ID Number _____ Social Security Number _____

DIRECTIONS

Please answer all questions by filling in the blank spaces or circling the appropriate responses. Answers to the following questions are for our records only and will be considered CONFIDENTIAL.

1. My last physical examination was on _____
2. The name of my physician is Dr. _____ Phone: _____
3. The name of my dentist is Dr. _____ Phone: _____
4. Are you in good health? ……..…… Yes No
5. Has there been any change in your general health within the past year? ……...Yes No
6. Are you now under the care of a physician or any other health practitioner? ……..…… Yes No
7. Have you been hospitalized or had any serious illness or operations? ……..…. Yes No
8. List any allergies to medication/latex/metals
   _____
   _____
9. Do you take aspirin on a regular basis (daily)? ___ Yes ___ No If Yes, what is the dosage _____

DENTAL HISTORY

10. Do you now have or have had any of the following: (please check)

___ Dental Pain
___ Food Packing Between Teeth
___ Bleeding Gums
___ Periodontal Disease/Treatment
___ Sensitive Teeth
___ Pain in or Near Ear
___ Difficulty in Opening Mouth
___ Injury to Face, Jaws, Teeth
___ Sinus Trouble
___ Dry Mouth
___ Sores in Mouth or Lips
___ Difficulty in Chewing
___ Dissatisfaction With Appearance of Teeth
___ Tumors of the Face, Jaws or Mouth

Do you frequently use hard/sticky candy, cough drops or mints? _____ Yes _____ NO
What's your daily frequency of soda or any sweetened beverages? _____ times daily

-OVER-

MEDICAL AND HEALTH HISTORY

11. Do you now have or have had any of the following: (Please Check)

___ Previous Bacterial Endocarditis
___ Heart Disease
___ Heart Murmur
___ Asthma/Hay Fever
___ Persistent Diarrhea
___ Radiation Treatment/Chemotherapy
___ Glaucoma
___ Seizures or Epilepsy
___ Stomach Ulcer
___ Kidney Disease or Transplant
___ Diabetes
___ Abnormal Bleeding or Bruising
___ Pacemaker
___ Prosthetic Heart Valves
___ Joint Replacements
___ High Blood Pressure
___ Blood Transfusions
___ Anemia
___ Cancer/Any Tumors
___ Alcohol or Drug Abuse
___ Hepatitis
___ Emphysema/Lung Disease
___ Arthritis
___ Fainting Spells
___ Nervousness
___ Herpes/Cold Sores
___ AIDS/ HIV
___ Tobacco Usage
___ Low Blood Pressure
___ Chest Pain Upon Exertion
___ Shortness of Breath
___ Swollen Ankles
___ Repeated Infections
___ Rapid Weight Loss or Gain
___ Swollen Glands
___ Unexplained Fever
___ Severe Night Sweats
___ Extreme Tiredness
___ Heavy Persistent Dry Cough
___ Tuberculosis
___ Venereal Disease
___ Liver Disease/Jaundice

Do you SMOKE? ____ Yes ____ No If Yes, how long? ____ Years ____ cigarettes per day, or quit ____ years ago.

MEDICATION QUESTIONNAIRE

Pre-medication before dental treatment? _____Yes _____No

Do you regularly take or consume(please check all that apply):

☐grapefruit juice or grapefruits
☐Antacids
☐Dilantin® or Tegretol®
☐Barbiturates®(any)
☐Aspirin
☐St. John's Wort or Kava-Kava
☐Tagament®(cimetidine) or Prilosec®(omeprazole)
☐Cardizem®(diltiazem) or Calan, Isoptin(verapamil)
☐Serzone®(nefazodone)
☐Diflucan®(fluconazole) or Sporanox(itraconazole)
☐Biaxin(clarithromycin)

Have you taken Prolia®, Zometa®, Fosamax®, Aredia®, Actonel®, or Boniva®? _____ Yes _____ No

If Yes, when did the treatment begin? _____ When did the treatment end? _____

Are you using any Street drugs? _____ Yes _____ No If Yes, what drugs? _____

Please list any medications you are currently taking and dosages:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

Please list any dietary or herbal or OTC supplements you are taking, and for what purpose:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

12. Please list any diseases, conditions or problems not included in the above medical and dental history?

_____

13. Name and phone number of whom to contact in case of an emergency

_____