



Loop Perio

PERIODONTICS & IMPLANTS

SUITE 2033
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312-782-4068 / FAX 312-782-6059
LOOPPERIO@GMAIL.COM

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)
- | | | |
|--|--|---|
| <input type="checkbox"/> Dental Pain | <input type="checkbox"/> Difficulty in Opening Mouth | <input type="checkbox"/> Dissatisfaction With Appearance of Teeth |
| <input type="checkbox"/> Food Packing Between Teeth | <input type="checkbox"/> Injury to Face, Jaws, Teeth | |
| <input type="checkbox"/> Bleeding Gums | <input type="checkbox"/> Sinus Trouble | |
| <input type="checkbox"/> Periodontal Disease/Treatment | <input type="checkbox"/> Dry Mouth | <input type="checkbox"/> Tumors of the Face, Jaws or Mouth |
| <input type="checkbox"/> Sensitive Teeth | <input type="checkbox"/> Sores in Mouth or Lips | |
| <input type="checkbox"/> Pain in or Near Ear | <input type="checkbox"/> Difficulty in Chewing | |

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)

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

- | | |
|---|---|
| <input type="checkbox"/> grapefruit juice or grapefruits | <input type="checkbox"/> Tagament [®] (cimetidine) or Prilosec [®] (omeprazole) |
| <input type="checkbox"/> Antacids | <input type="checkbox"/> Cardizem [®] (diltiazem) or Calan, Isoptin (verapamil) |
| <input type="checkbox"/> Dilantin [®] or Tegretol [®] | <input type="checkbox"/> Serzone [®] (nefazodone) |
| <input type="checkbox"/> Barbiturates [®] (any) | <input type="checkbox"/> Diflucan [®] (fluconazole) or Sporanox (itraconazole) |
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Biaxin (clarithromycin) |
| <input type="checkbox"/> St. John's Wort or Kava-Kava | |

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. <input type="text"/> | 5. <input type="text"/> |
| 2. <input type="text"/> | 6. <input type="text"/> |
| 3. <input type="text"/> | 7. <input type="text"/> |
| 4. <input type="text"/> | 8. <input type="text"/> |

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

- | | |
|-------------------------|-------------------------|
| 1. <input type="text"/> | 5. <input type="text"/> |
| 2. <input type="text"/> | 6. <input type="text"/> |
| 3. <input type="text"/> | 7. <input type="text"/> |
| 4. <input type="text"/> | 8. <input type="text"/> |

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