Joseph L. Rumfola, DDS **Patient Name:** _____

MEDICAL/DENTAL HISTORY QUESTIONNAIRE

Weight _____ Height_____ Date of birth _____ ❑ Married ❑ Single
Are you currently under the care of a physician? ❑ Yes ❑ No Occupation _____
Physician's name: _____ Physician's Telephone #: _____

Physician's address: _____

My last physical examination was on: _____

Do you have, or have you had any of the following conditions:	Yes	No	Not sure
1. Rheumatic fever or rheumatic heart disease?	❑	❑	❑
2. Cardiovascular disease (heart attack, angina, coronary bypass, high blood pressure, arterial sclerosis, stroke, pace maker)? Please circle all that apply.	❑	❑	❑
3. Joint replacement surgery (shoulder, knee, hip)? Heart valve replacement?	❑	❑	❑
4. Allergic reactions to food or drugs?	❑	❑	❑
5. Asthma?	❑	❑	❑
6. Fainting spells or seizures?	❑	❑	❑
7. Diabetes?	❑	❑	❑
8. Hepatitis or liver disease?	❑	❑	❑
9. Osteoporosis?	❑	❑	❑
10. Cancer?	❑	❑	❑
11. Thyroid disorder?	❑	❑	❑
12. Arthritis?	❑	❑	❑
13. Stomach ulcers?	❑	❑	❑
14. Kidney disorder?	❑	❑	❑
15. Tuberculosis?	❑	❑	❑
16. HIV/AIDS?	❑	❑	❑
17. Blood disorder (such as anemia)?	❑	❑	❑
18. Surgery or radiation treatment of your head or neck?	❑	❑	❑
19. Frequent headaches?	❑	❑	❑
Are you allergic to, or have you reacted adversely to any of the following:			
1. Local anesthetics (i.e. novocaine)?	❑	❑	❑
2. Penicillin or other antibiotics?	❑	❑	❑
3. Aspirin?	❑	❑	❑
4. Sulfa drugs?	❑	❑	❑
5. Iodine?	❑	❑	❑
6. Latex?	❑	❑	❑
Have you had any abnormal bleeding from previous dental extractions, surgery or trauma?	❑	❑	❑
Have you had any serious trouble associated with any previous dental treatment?	❑	❑	❑
Women: Are you pregnant?	❑	❑	❑

Do you (please check any that apply) ❑ smoke, ❑ drink alcohol, or ❑ use recreational drugs?
Do you have any disease, condition, or problem that you think I should know about, not listed above?

Are you currently taking any drugs, medicine, vitamins, or herbal supplements? ❑ ❑
**** If yes, please bring a complete list noting name, dosage, and approximate date started.**

Joseph L. Rumfola, DDS **Patient Name:**_____

MEDICAL/DENTAL HISTORY QUESTIONNAIRE (continued)

Chief dental complaint: _____

When was your last visit to a dentist? _____

What treatment did you receive? _____

Why did you leave your previous dentist? _____

How often do you brush your teeth? _____ floss? _____

Are your teeth sensitive to (please check all that apply) ❑ hot, ❑ cold, ❑ sweets, ❑ biting pressure?

How long since your last *thorough* dental examination with *full mouth x-rays*? _____

	Yes	No
Are you aware of any swelling, soreness, rough areas, ulcers, or color changes in your mouth?	❑	❑
Does floss catch, fray, or break in area of your mouth?	❑	❑
Does food constantly get stuck between certain teeth in your mouth?	❑	❑
Have you ever had any teeth removed?	❑	❑
Do you have dentures/partial dentures?	❑	❑
Do you grind, clench, or grit your teeth?	❑	❑
Do you have or have you had any pain in your jaw joint or muscles?	❑	❑
Do your gums bleed when brushing?	❑	❑
Do you ever avoid any part of the mouth while brushing?	❑	❑
Do you have an unpleasant taste or odor in your mouth?	❑	❑
Do you brush your tongue?	❑	❑
Do you experience dry mouth?	❑	❑
Do you frequently snack on sweets between meals or chew gum?	❑	❑
Are you dissatisfied with your teeth in any way?	❑	❑
Do you dislike the way your teeth look (color, shape, spacing, etc.)?	❑	❑
Do you have any fillings that show in your front teeth?	❑	❑
Do any of your fillings show when you smile?	❑	❑
If any of your silver fillings need replacement, would you prefer to have a tooth colored restoration?	❑	❑
Do you play any sports in which a mouth guard would be beneficial?	❑	❑
Do you experience frustration because you always have something to be repaired or treated when you visit a dentist?	❑	❑
Has the fear of discomfort kept you from regular dental visits?	❑	❑
Are you deeply concerned about the finances required to return your mouth to excellent dental health?	❑	❑
Have you ever been instructed regarding proper dental home care?	❑	❑

(For office use only) VITAL STATISTICS Date: _____

Pulse: _____bpm Resp. rate: _____breaths/min Blood Pressure: _____/_____mmHg

Hx. of smoking/alcohol consumption: _____

All of the above information is for record keeping purposes only and will be considered confidential. By signing below, I certify that the above information is true to the best of my knowledge and agree to notify this office if there are any changes in my medical status.

_____ _____

Signature of Patient/Parent(Guardian) Date Signature of Dentist Date

Joseph L. Rumfola, DDS

RECORDS RELEASE AUTHORIZATION

Patient Name: _____ DOB: _____

Prior Dental Office: _____

To Whom It May Concern:

I authorize you to furnish the following to Dr. Joseph Rumfola:

- ☐ Current X-rays
- ☐ Treatment Record
- ☐ Treatment Plan
- ☐ Complete Chart

_____

Patient's Signature

Date: _____

X-rays can be emailed to **info@rumfoladds.com**
(please include the dates the x-rays were taken)

Hard copies can be mailed to:
Joseph L. Rumfola, DDS
396 Waverly St
Springville, NY 14141

Or faxed to: **(716) 592-2885**

If there are any questions, please call: **(716) 592-3810**