CHRIS LEISZLER, DDS
FAMILY & COSMETIC DENTISTRY

MEDICAL HISTORY QUESTIONNAIRE

Today's Date:_________ Name:______________________________ Date of Birth:_____________
Home Address:____
____
Home Phone:________________ Cell Phone:________________ Work Phone:__________________
E-Mail Address:____

□ What is the approximate date of your last doctor's visit? ____________________________________

□ Name and phone number of your physician: ____

□ Are you under medical treatment now? ___ Yes ___ No
If yes, please describe: ____

□ Are you taking any medications, including non-prescription medications? ___ Yes ___ No
If yes, please list them below:

____ ____
____ ____
____ ____
____ ____
____ ____

□ Have you ever taken prescription medications for weight loss? ___ Yes ___ No
If yes, did you take any of the following?:
___ Fen-Phen (Fenfluramine-Phentermine)
___ Pondimen (Fenfluramine)
___ Redux (Dexfenfluramine)
___ Other__________________________
___ Don't remember

□ Do you have a persistent cough or throat clearing not associated with a known illness, lasting more than three weeks? ___ Yes ___ No

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□ Do you have or have you had any of the following?:

___ High Blood Pressure
___ Low Blood Pressure
___ Heart Attack
___ Rheumatic Fever
___ Heart Disease
___ Pacemaker
___ Heart Murmur
___ Angina
___ Chest Pains
___ Stroke
___ Cancer
___ Chemotherapy
___ Radiation Therapy
___ Drug or Alcohol Abuse
___ Arthritis
___ Swollen Ankles
___ Joint Replacement
___ Respiratory Problems
___ Asthma
___ Hay Fever/Allergies
___ Thyroid Problems
___ Diabetes
___ Kidney Diseases
___ Liver Disease
___ Hepatitis/Jaundice
___ STDs
___ Recent Weight Loss
___ Psychological Disorders
___ Stomach Problems (ulcers, colitis, etc.)
___ Fainting/Loss of Consciousness
___ Epilepsy/Seizures
___ Easily Winded
___ Frequently Tired
___ Abnormal Blood Conditions (hemophilia)
___ AIDS or HIV
___ Leukemia
___ Anemia
___ Emphysema
___ Glaucoma
___ Tuberculosis
___ Mitral Valve Prolapse
___ Other_________________________________

MEDICAL HISTORY QUESTIONNAIRE

Today's Date:_________ Name:______________________________ Date of Birth:__________

□ Are you allergic to, or have you had any reactions to the following?:

___ Local Anesthetics (i.e. Novocaine)
___ Sedatives
___ Penicillin or Amoxicillin
___ Other Antibiotics (i.e. Erythromycin, Tetracycline)
___ Aspirin
___ Food Allergies
___ Codeine
___ Sulfa Drugs
___ Barbiturates
___ Latex Rubber
___ Any Metals (Nickel, Mercury, etc.)
___ Other_______________________________

□ Do you have frequent headaches? ___ Yes ___ No

□ Are you wearing contact lenses? ___ Yes ___ No

□ Women only: Are you pregnant or do you think you may be pregnant? ___ Yes ___ No
If you are pregnant, how many weeks? ____________________________________
Are you nursing? ___ Yes ___ No
Are you taking oral contraceptives (birth control pills)? ___ Yes ___ No

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□ I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the doctor to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such medical care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the doctor or doctor group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for service. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature: ____