



CHRIS LEISZLER, DDS
FAMILY & COSMETIC DENTISTRY

CHILD DENTAL HISTORY QUESTIONNAIRE

Today's Date: _____ Name: _____ Date of Birth: _____

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- Is this your child's first visit to a dentist? ___ Yes ___ No
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- If this is not a first visit, how long since the last visit to the dentist? _____
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- Were any x-rays taken when your child previously visited the dentist? ___ Yes ___ No
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- Does your child snack between meals? ___ Yes ___ No
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- Does your child eat many sweets such as candy, soft drinks, or chewing gum? ___ Yes ___ No
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- When does your child brush his/her teeth? (Mark all that apply.)
___ Upon arising ___ After eating any food ___ Right after meals ___ Before going to bed
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- Have any cavities been noted in the past? ___ Yes ___ No
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- Does your child suck his/her thumb or fingers? ___ Yes ___ No
-
- Have any teeth been permanently extracted? ___ Yes ___ No
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- If any teeth were extracted, was it suggested that the space be maintained?
___ Yes ___ No ___ I don't know
-
- If any teeth were extracted, was an appliance placed? ___ Yes ___ No ___ I don't know
-
- Have there been any injuries to teeth (chipped, cracked, discolored, etc.)? ___ Yes ___ No
If yes, please describe: _____
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- Has your child had any problems with dental treatment in the past? ___ Yes ___ No
If yes, please describe: _____
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- Has anyone in the family, including parents, had orthodontics? ___ Yes ___ No
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- Has your child ever received local anesthetic? ___ Yes ___ No
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- Has your child ever had sealants placed on his/her teeth? ___ Yes ___ No
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- Does your child report anything being wrong with his/her teeth? ___ Yes ___ No
If yes, please describe: _____

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE TO THE BEST OF MY KNOWLEDGE:

Signature: _____ **Date:** _____