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**CHILD MEDICAL HISTORY QUESTIONNAIRE**

Today's Date: \_\_\_\_\_ Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Does your child have a health problem? \_\_\_ Yes \_\_\_ No  
If yes, please describe: \_\_\_\_\_

Is your child under the care of a physician? \_\_\_ Yes \_\_\_ No

If your child has a physician, what is his/her name and phone number? \_\_\_\_\_

Does your child snack between meals? \_\_\_ Yes \_\_\_ No

Is your child taking any medications? \_\_\_ Yes \_\_\_ No  
If yes, please list: \_\_\_\_\_  
\_\_\_\_\_

Is your child allergic to any of the following? \_\_\_ Antibiotics or other drugs: \_\_\_\_\_  
\_\_\_ Latex or rubber gloves  
\_\_\_ Any metals: \_\_\_\_\_  
\_\_\_ Any foods: \_\_\_\_\_  
\_\_\_ Seasonal allergies  
\_\_\_ Other: \_\_\_\_\_

Has your child ever been hospitalized? \_\_\_ Yes \_\_\_ No  
If yes, please describe, including dates: \_\_\_\_\_

Has your child ever had surgery? \_\_\_ Yes \_\_\_ No  
If yes, please describe, including dates: \_\_\_\_\_

Does your child have or has your child had any of the following?

___ Asthma	___ Mental disorder
___ Diabetes	___ Vision problem
___ Heart disorder	___ Cancer
___ Kidney disorder	___ Infections
___ Rheumatic Fever	___ Speech impairments
___ Epilepsy	___ Hearing loss
___ Cerebral Palsy	___ AIDS or HIV
___ Liver disorder	___ Hepatitis
___ Blood disorder	___ Other: _____
___ Congenital birth defect	___ Other: _____

Is your child subject to any Nervous System disorders? \_\_\_ Yes \_\_\_ No  
\_\_\_ Fainting \_\_\_ Seizures \_\_\_ Anxiety \_\_\_ Behavioral/Learning Problems \_\_\_ Other: \_\_\_\_\_

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

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_