

Child

Confidential Social & Medical History

Parent/Guardian Name: _____
 Contact Number: _____
 Social Worker Details: _____
 Social worker Phone: _____
 Child's School: _____
 School Address: _____

PATIENT LABEL	
Child's name:
Date of Birth:

PLEASE CIRCLE
 Can you consent/give permission for treatment? **yes** **no**
 Are you named on child's birth certificate? **yes** **no**
 Is anyone else named on child's birth certificate? **yes** **no**

Name: _____

Medical Details

HAS YOUR CHILD:	YES	NO	DETAILS
Good health?	<input type="checkbox"/>	<input type="checkbox"/>	_____
All childhood vaccinations?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other hospital/clinic visits?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Appointments with a paediatrician?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Any operations or serious illness?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sedation or general anaesthetic?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Premature birth/birth difficulties?	<input type="checkbox"/>	<input type="checkbox"/>	_____
History of sleep apnoea/snoring?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Learning difficulty, ADHD, Autism?	<input type="checkbox"/>	<input type="checkbox"/>	_____

Medication/Medicines/Creams/Supplements

Details (including dose and frequency)	Date started	Date stopped

PLEASE TURN OVER

Does your child, or has your child had, any problems with:

	YES	NO	DETAILS
Chest? e.g. asthma, bronchitis, shortness of breath, cough			
Heart? e.g. murmur, heart defect, surgery, palpitations			
Blood or Circulation? e.g. anaemia, prolonged bleeding, blood pressure			
Digestion, Stomach or Intestines? e.g. reflux, jaundice, colitis, constipation, ulcers			
Kidneys? e.g. kidney function, infections			
Nervous system? e.g. fits/epilepsy/autism/learning difficulty			
Hormonal system? e.g. diabetes, thyroid			
Joints and bones? e.g. arthritis, muscle problems			
Skin & mucous membranes? e.g. eczema, psoriasis, ulcers			
Allergies and sensitivities? e.g. foods, medications, materials			
History of family illness? e.g. sickle cell anaemia, thalassaemia, inherited conditions			
Infectious disease? e.g. hepatitis, HIV, TB, CJD			

OLDER CHILDREN	YES	NO	DETAILS
Do you use tobacco, e-cigarettes or vape?			
Do you drink alcohol?			
Do you use recreational drugs?			
Is it possible you could be pregnant?			

Further information:

Checked & signed by Dentist/Doctor					
Print name					
Date					