

Child

Confidential Social & Medical History

Parent/Guardian Name:				PATIENT LABEL
Contact Number:				
Social Worker Details:				Child's name:
Social worker Phone:				Date of Birth:
Child's School:				Date of birth.
School Address:				
Can you consent/give permission for treatment? Are you named on child's birth certificate? Is anyone else named on child's birth certificate?		yes no yes no yes no	Name:	
Medical Details				
HAS YOUR CHILD:	YES	NO	DETAILS	
Good health?				
All childhood vaccinations?				
Other hospital/clinic visits?				
Appointments with a paediatrician?				
Any operations or serious illness?				
Sedation or general anaesthetic?				
Premature birth/birth difficulties?				
History of sleep apnoea/snoring?				
Learning difficulty, ADHD, Autism?				

Medication/Medicines/Creams/Supplements

Details (including dose and frequency)	Date started	Date stopped

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

Chest? e.g. asthma, bronchitis, shortness of breath, cough Heart? e.g. murmur, heart defect, surgery, palpitations Blood or Circulation? e.g. anamia, 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. ezerma, psoriasis, ulcers e.g. sickle cell anaemia, thalassaemia, inherited conditions Infectious disease? e.g. sickle cell anaemia, thalassaemia, inherited conditions Infectious disease? e.g. hepatitis, HIV, TB, CJD Do you use tobacco, e-cigarettes or vape? Do you use recreational drugs? Is it possible you could be pregnant? Further information: Checked & signed by Dentist/Doctor Print name Date D		YES	NO	DETAILS
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