

PLEASE USE BLACK PEN

CONFIDENTIAL MEDICAL/DENTAL HISTORY FORM

Your child's details	Surname:		
	Given names:		Preferred name:
	No/Street:		
	Suburb/Town:		Postcode:
	Date of Birth: / /	Weight: kg	Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male
	Medicare Number:	Reference:	Expiry date:
Parent / Guardian details [person who will be liaising with us the most, and responsible for payment of invoice]	Surname:		First name:
	Title:		Relationship to child:
	No/Street:		
	Suburb/Town:		Postcode:
	Phone (Home):	(Mob):	(Work):
	eMail:		
	Occupation:		
Private Health Fund:	Type of Cover (eg hospital, extras only)	Membership Number:	
Other Parent / Guardian details	Surname:		First name:
	Title:		Relationship to child:
	No/Street:		
	Suburb/Town:		Postcode:
	Phone (Home):	(Work):	(Mob):
	eMail:		
	Occupation:		
Your child's dental history	Who is your child's general dentist? Name/Address:		
	Is your child attending another dental specialist? <input type="checkbox"/> No <input type="checkbox"/> Yes Name/Address/Reason:		
	Please list any concerns you have regarding your child's teeth or mouth:		
	Has your child suffered any injury in the past, to the mouth or teeth? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, please describe: _____		
	How frequently are your child's teeth brushed? _____ Who does this? <input type="checkbox"/> Child <input type="checkbox"/> Parent _____ What type of tooth past is most commonly used? _____		

Pregnancy and birth history	Any pregnancy complications? _____ Gestational age: Full term <input type="checkbox"/> or Other _____ Birth weight: _____ Any complications during labour or during/after delivery? _____ _____ Medical problems during 0-3 years (including chickenpox, respiratory conditions, ear infections, UTI): _____																																																																																																																																																								
Your child's medical history	I have information about my child that I do not wish to write down. I would prefer to speak to the specialist about (<i>please tick</i>): Medical information <input type="checkbox"/> Social or family information <input type="checkbox"/> DOES YOUR CHILD HAVE OR HAS YOUR CHILD HAD ANY OF THE FOLLOWING? <i>(please tick and provide further details below)</i> <table border="1" style="width: 100%; border-collapse: collapse; margin-top: 5px;"> <thead> <tr> <th style="width: 45%;"></th> <th style="width: 5%;"></th> <th style="width: 5%;">No</th> <th style="width: 5%;">Yes</th> <th style="width: 40%;"></th> <th style="width: 5%;"></th> <th style="width: 5%;">No</th> <th style="width: 5%;">Yes</th> </tr> </thead> <tbody> <tr> <td>Complications during pregnancy</td> <td><input type="checkbox"/></td> <td></td> <td><input type="checkbox"/></td> <td>Diabetes</td> <td><input type="checkbox"/></td> <td></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Complications during birth or infancy</td> <td><input type="checkbox"/></td> <td></td> <td><input type="checkbox"/></td> <td>Glandular disorders (eg thyroid)</td> <td><input type="checkbox"/></td> <td></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Brain injury or illness</td> <td><input type="checkbox"/></td> <td></td> <td><input type="checkbox"/></td> <td>Skin conditions</td> <td><input type="checkbox"/></td> <td></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Psychiatric or mental illness</td> <td><input type="checkbox"/></td> <td></td> <td><input type="checkbox"/></td> <td>Bleeding disorder</td> <td><input type="checkbox"/></td> <td></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Developmental delay</td> <td><input type="checkbox"/></td> <td></td> <td><input type="checkbox"/></td> <td>Excessive bleeding</td> <td><input type="checkbox"/></td> <td></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Autism Spectrum Disorder</td> <td><input type="checkbox"/></td> <td></td> <td><input type="checkbox"/></td> <td>Anaemia</td> <td><input type="checkbox"/></td> <td></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Attention or learning disorder</td> <td><input type="checkbox"/></td> <td></td> <td><input type="checkbox"/></td> <td>Leukaemia or other blood disorder</td> <td><input type="checkbox"/></td> <td></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Epilepsy</td> <td><input type="checkbox"/></td> <td></td> <td><input type="checkbox"/></td> <td>Immune disorder</td> <td><input type="checkbox"/></td> <td></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Prosthetic implant, eg. shunt</td> <td><input type="checkbox"/></td> <td></td> <td><input type="checkbox"/></td> <td>Contact with HIV / AIDS</td> <td><input type="checkbox"/></td> <td></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Heart condition</td> <td><input type="checkbox"/></td> <td></td> <td><input type="checkbox"/></td> <td>Radiation therapy</td> <td><input type="checkbox"/></td> <td></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Heart valve disorder, eg. murmur</td> <td><input type="checkbox"/></td> <td></td> <td><input type="checkbox"/></td> <td>Chemotherapy</td> <td><input type="checkbox"/></td> <td></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Rheumatic fever</td> <td><input type="checkbox"/></td> <td></td> <td><input type="checkbox"/></td> <td>Steroid Therapy</td> <td><input type="checkbox"/></td> <td></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Blood pressure disorder</td> <td><input type="checkbox"/></td> <td></td> <td><input type="checkbox"/></td> <td>Admitted to hospital</td> <td><input type="checkbox"/></td> <td></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Lung disease</td> <td><input type="checkbox"/></td> <td></td> <td><input type="checkbox"/></td> <td>Cleft lip/palate or other craniofacial</td> <td><input type="checkbox"/></td> <td></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Asthma</td> <td><input type="checkbox"/></td> <td></td> <td><input type="checkbox"/></td> <td>Physical disability</td> <td><input type="checkbox"/></td> <td></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Intestinal disorder</td> <td><input type="checkbox"/></td> <td></td> <td><input type="checkbox"/></td> <td>Hearing or sight problems</td> <td><input type="checkbox"/></td> <td></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Hepatitis or other liver disease</td> <td><input type="checkbox"/></td> <td></td> <td><input type="checkbox"/></td> <td>Pregnant</td> <td><input type="checkbox"/></td> <td></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Kidney disease</td> <td><input type="checkbox"/></td> <td></td> <td><input type="checkbox"/></td> <td>Other (see below)</td> <td><input type="checkbox"/></td> <td></td> <td><input type="checkbox"/></td> </tr> </tbody> </table> <p>If you answered YES to any of the above, please provide details:</p> <p>Other conditions not listed above:</p> <p>Does your child have any allergies (including latex)? <input type="checkbox"/> No <input type="checkbox"/> Yes Please list:</p> <p>Is your child taking any tablets, medications or lotions (prescribed or over-the-counter)? <input type="checkbox"/> No <input type="checkbox"/> Yes Please list:</p> <p>Does your child see any other specialists? Does your child have a general medical practitioner? Name: _____ Address: _____</p> <p>Does your child normally require antibiotic cover before dental treatment? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Does your child have any abnormal reactions to local or general anaesthesia? <input type="checkbox"/> No <input type="checkbox"/> Yes Details:</p>			No	Yes			No	Yes	Complications during pregnancy	<input type="checkbox"/>		<input type="checkbox"/>	Diabetes	<input type="checkbox"/>		<input type="checkbox"/>	Complications during birth or infancy	<input type="checkbox"/>		<input type="checkbox"/>	Glandular disorders (eg thyroid)	<input type="checkbox"/>		<input type="checkbox"/>	Brain injury or illness	<input type="checkbox"/>		<input type="checkbox"/>	Skin conditions	<input type="checkbox"/>		<input type="checkbox"/>	Psychiatric or mental illness	<input type="checkbox"/>		<input type="checkbox"/>	Bleeding disorder	<input type="checkbox"/>		<input type="checkbox"/>	Developmental delay	<input type="checkbox"/>		<input type="checkbox"/>	Excessive bleeding	<input type="checkbox"/>		<input type="checkbox"/>	Autism Spectrum Disorder	<input type="checkbox"/>		<input type="checkbox"/>	Anaemia	<input type="checkbox"/>		<input type="checkbox"/>	Attention or learning disorder	<input type="checkbox"/>		<input type="checkbox"/>	Leukaemia or other blood disorder	<input type="checkbox"/>		<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>		<input type="checkbox"/>	Immune disorder	<input type="checkbox"/>		<input type="checkbox"/>	Prosthetic implant, eg. shunt	<input type="checkbox"/>		<input type="checkbox"/>	Contact with HIV / AIDS	<input type="checkbox"/>		<input type="checkbox"/>	Heart condition	<input type="checkbox"/>		<input type="checkbox"/>	Radiation therapy	<input type="checkbox"/>		<input type="checkbox"/>	Heart valve disorder, eg. murmur	<input type="checkbox"/>		<input type="checkbox"/>	Chemotherapy	<input type="checkbox"/>		<input type="checkbox"/>	Rheumatic fever	<input type="checkbox"/>		<input type="checkbox"/>	Steroid Therapy	<input type="checkbox"/>		<input type="checkbox"/>	Blood pressure disorder	<input type="checkbox"/>		<input type="checkbox"/>	Admitted to hospital	<input type="checkbox"/>		<input type="checkbox"/>	Lung disease	<input type="checkbox"/>		<input type="checkbox"/>	Cleft lip/palate or other craniofacial	<input type="checkbox"/>		<input type="checkbox"/>	Asthma	<input type="checkbox"/>		<input type="checkbox"/>	Physical disability	<input type="checkbox"/>		<input type="checkbox"/>	Intestinal disorder	<input type="checkbox"/>		<input type="checkbox"/>	Hearing or sight problems	<input type="checkbox"/>		<input type="checkbox"/>	Hepatitis or other liver disease	<input type="checkbox"/>		<input type="checkbox"/>	Pregnant	<input type="checkbox"/>		<input type="checkbox"/>	Kidney disease	<input type="checkbox"/>		<input type="checkbox"/>	Other (see below)	<input type="checkbox"/>		<input type="checkbox"/>
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Consent: I consent to clinical examination, x-rays and of collection of clinical records (including photographs) of my child.

Parent/Guardian Name

Signature

Date