MILLER & ISAACS AT
cleeve DENTAL

CHILD MEDICAL HISTORY FORM

Patient's Full Name: _____

Patient's Gender: [ ] Male [ ] Female Date of Birth: _____

Home Address: _____

_____ Postcode: _____

GP Name & Surgery: _____ NHS Number: ☐☐☐ ☐☐☐ ☐☐☐☐

As Parent/Guardian, I confirm that I have Legal Parental Responsibility of the above named child.*

Parent/Guardian's Full Name: _____ Relation to Child: _____

Parent/Guardian Contact: Telephone _____ Mobile _____

Parent/Guardian Email: _____

At Miller & Isaacs Dental Surgery, we take great care with all Personal Data we hold, to ensure we comply with best professional practice and the law.
For a full copy of our Data Privacy Notice please see our website or our waiting room notice board.

HAS THE CHILD HAD ANY HISTORY OF, OR CONDITIONS RELATED TO ANY OF THE FOLLOWING: PLEASE TICK IF ANSWER IS YES

[ ] ADD/ADHD
[ ] AIDS
[ ] Anaemia
[ ] Anxiety Disorder
[ ] Arthritis
[ ] Asthma/Breathing
[ ] Autism
[ ] Aspergers
[ ] Bladder
[ ] Bleeding
[ ] Blood Dyscrasia
[ ] Bones/Joints
[ ] Cancers/Tumours
[ ] Cerebral Palsy
[ ] Cleft Lip/Palate
[ ] Congenital Birth Defects
[ ] Chronic Sinusitis
[ ] Diabetes
[ ] Earaches
[ ] Eating Disorder
[ ] Endocrine/Growth
[ ] Epilepsy
[ ] Eyesight
[ ] Fainting
[ ] Frequent Infections
[ ] Heart Disease
[ ] Heart Murmur
[ ] Hepatitis
[ ] History of Abuse
[ ] Immunisation Complications
[ ] Kidney Disease
[ ] Liver/Gastrointestinal Disease
[ ] Latex Allergy
[ ] Measles
[ ] Mumps
[ ] Personality/Social Disorders
[ ] Recurrent Headaches
[ ] Recurrent Herpes/Cold Sores**
[ ] Rheumatic fever
[ ] Seizures
[ ] Sickle Cell Disease/Trait
[ ] Significant Injuries
[ ] Snoring
[ ] Speech/Hearing
[ ] Spina Bifida
[ ] Thyroid
[ ] Tobacco/Drug Use
[ ] Tuberculosis
[ ] Venereal Disease
[ ] Other: _____

** Please note that if your child has an active herpes lip lesion on the day of your scheduled appointment , we will ask you to reschedule.

If any boxes are ticked, please explain: _____

CHILD'S HISTORY

1. Is the child taking any prescribed and/or over the counter medications or vitamin supplements at this time? ..... YES NO
   If yes, please list:.....
2. Is the child allergic to any medications, i.e. Penicillin, antibiotics or any other drugs?..... YES NO
   If yes, please explain: .....
3. Is the child allergic to anything else, such as certain foods? ..... YES NO
   If yes, please explain: .....
4. Has the child ever had a serious illness?..... YES NO
   Is yes, when? _____ Please describe:.....
5. Has the child ever been hospitalised? ..... YES NO

CHILD'S HISTORY continued

6. Does the child has a history of any other illness? ..... YES NO
7. Has the child ever had a general anaesthetic? ..... YES NO
8. Does the child have any inherited problems? ..... YES NO
9. Has the child ever had a blood transfusion? ..... YES NO
10. Is the child physically, mentally or emotionally impaired? ..... YES NO
11. Does the child experience excessive bleeding when cut? ..... YES NO
12. Is the child being treated for any other illness? ..... YES NO
13. Is the child under a Child Protection Plan? ..... YES NO

CHILD'S DENTAL HISTORY

14. Has your child ever been to the Dentist? ..... YES NO
    Date of last visit? _____ Date of last X-Rays(if taken)? _____
    Name of previous Dentist? .....
    Previous Dental Surgery? .....
15. Has your child experienced any unfavourable reaction from previous dental care? ..... YES NO
    Please explain: .....
16. Has the child ever sucked their finger, thumb or a pacifier (dummy)? ..... YES NO
    Do they still? .....
17. Does the child have pain with chewing, yawning or opening wide? ..... YES NO
18. Does the child go to bed with a bottle or Sippy cup? ..... YES NO
19. Does the child snack regularly? ..... YES NO
    What are their favourite snack foods? .....
20. Has the child ever had a local anaesthetic? ..... YES NO
    If yes, were there any problems? .....
21. Has the child ever suffered any injuries to the mouth, head or teeth? ..... YES NO
    If yes, please explain: .....
22. Has the child had any problems with eruption or shedding of teeth? ..... YES NO
23. Has the child had any orthodontic treatment? ..... YES NO
24. What type of water does your child drink? [ ] Tap [ ] Bottled [ ] Filtered [ ] Fizzy
25. Does the child take fluoride supplements? ..... YES NO
26. Is fluoride toothpaste used? ..... YES NO
27. How many times a day are the child's teeth brushed? _____ When? .....
    By whom? .....
28. At what age did the child stop bottle feeding? Age: _____
29. Does the child participate in recreational activities? ..... YES NO
    If yes, what? .....

CONSENT FOR DENTAL TREATMENT: As Parent /Guardian with Legal Parental Responsibility of the above named child, I do hereby request and authorise the Dentists and their Professional Clinical Staff at Miller and Isaacs Dental Surgery to examine and provide treatment as appropriate for the patient. I further authorise the taking of dental x-rays as may be considered necessary by the Dentist. **I will/will not** allow photographs to be taken of the patient's teeth for diagnostic or educational purposes. I understand that Dental Treatment for children includes efforts to guide their behaviour by helping them understand treatment in terms appropriate for their age. I affirm that the information I have given is correct to the best of my knowledge. I understand it is my responsibility to inform Miller & Isaacs Dental Surgery of any changes in the patient's medical status.

Full Name Printed:

Signature: **Date:**

AUTHORISED PERSONS

*** As Parent/Guardian, I confirm that I am that I have Legal Parental Responsibility of the named child herein.** If I am unable to attend with the named child I give consent for the following people to attend with the patient and give consent for treatment.

Printed Name of Approved Guardian	Relationship to Patient	**Date** and **Signature** of Parent giving permission

MEDICAL HISTORY UPDATE

Please check that the health information for the named Child's Medical History is still correct. If not, amend as necessary or note any changes below. **As Parent/Guardian, I confirm that I am that I have Legal Parental Responsibility of the child named herein.**

Date	Any changes? Yes/No	Please note any changes below	Printed **Name** and **Signature** of Parent/Guardian	GDP Checked

MEDICAL HISTORY UPDATE continued

Please check that the health information on the named Child's Medical History is still correct. If not, amend as necessary or note any changes below. **As Parent/Guardian, I confirm that I am that I have Legal Parental Responsibility of the child named herein.**

Date	Any changes? Yes/No	Please note any changes below	Printed **Name** and **Signature** of Parent/Guardian	GDP Checked