paediatric DENTAL GROUP
Specialist care for kids

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SPECIALIST PRACTICE:
Brisbane
Ipswich
Toowoomba

PLEASE USE BLACK PEN WHEN FILLING OUT

CONFIDENTIAL MEDICAL/DENTAL HISTORY FORM

Your child's details	Surname:	
	Given names:	Preferred name:
	Date of Birth: / /	Gender: ☐ Female ☐ Male
	School:	Grade/Class:
	Private Health Fund:	
	Type of Cover (eg hospital, extras only)	Membership Number:
	Medicare Number:	Reference: Expiry date:
Parent / Guardian details (Correspondence will be sent here)	Surname:	Title:
	Given names:	Relationship to child:
	No/Street:	
	Suburb/Town:	Postcode:
	Phone (Home): (Work):	(Mob):
	eMail:	
	Occupation:	
	Preferred communication method: ☐ telephone	☐ mail ☐ email
Other Parent / Guardian details	Surname:	Title:
	Given names:	Relationship to child:
	No/Street:	
	Suburb/Town:	Postcode:
	Phone (Home): (Work):	(Mob):
	eMail:	
	Occupation:	
Your child's dental history	Who is your child's usual general dentist? Name/Address:	
	Is your child attending another dental specialist? Name/Address/Reason:	☐ No ☐ Yes
	Please list any concerns you have regarding your child's teeth or mouth:	
Pregnancy and birth history	Any pregnancy complications? ________________	
	Gestational age: Full term ☐ 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): ________________	

 Please turn over ➔

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 *(please tick)*: Medical information ☐ Social or family information ☐

DOES YOUR CHILD HAVE OR HAS YOUR CHILD HAD ANY OF THE FOLLOWING?
(please tick and provide further details below)

	No	Yes		No	Yes
Complications during pregnancy	☐	☐	Diabetes	☐	☐
Complications during birth or infancy	☐	☐	Glandular disorders (eg thyroid)	☐	☐
Brain injury or illness	☐	☐	Skin conditions	☐	☐
Psychiatric or mental illness	☐	☐	Bleeding disorder	☐	☐
Developmental delay	☐	☐	Excessive bleeding	☐	☐
Autism Spectrum Disorder	☐	☐	Anaemia	☐	☐
Attention or learning disorder	☐	☐	Leukaemia or other blood disorder	☐	☐
Epilepsy	☐	☐	Immune disorder	☐	☐
Prosthetic implant, eg. shunt	☐	☐	Contact with HIV / AIDS	☐	☐
Heart condition	☐	☐	Radiation therapy	☐	☐
Heart valve disorder, eg. murmur	☐	☐	Chemotherapy	☐	☐
Rheumatic fever	☐	☐	Steroid Therapy	☐	☐
Blood pressure disorder	☐	☐	Admitted to hospital	☐	☐
Lung disease	☐	☐	Cleft lip/palate or other craniofacial	☐	☐
Asthma	☐	☐	Physical disability	☐	☐
Intestinal disorder	☐	☐	Hearing or sight problems	☐	☐
Hepatitis or other liver disease	☐	☐	Pregnant	☐	☐
Kidney disease	☐	☐	Other (see below)	☐	☐

If you answered YES to any of the above, please provide details:

Other conditions not listed above:

Does your child have any allergies (including latex)? ☐ No ☐ Yes
Please list:

Is your child taking any tablets, medications or lotions (prescribed or over-the-counter)?
Please list: ☐ No ☐ Yes

Does your child see any other specialists? Does your child have a general medical practitioner?
Name: Address:

Does your child normally require antibiotic cover before dental treatment? ☐ No ☐ Yes

Does your child have any abnormal reactions to local or general anaesthesia?
Details: ☐ No ☐ Yes

Consent: I consent to clinical examination, x-rays and of collection of clinical records (including photographs) of my child.

Parent/Guardian Name ____________ Signature ____________ Date ____________

Reviewed by specialist: ____________