NHS England

# Medical History Form

Please provide us with the following information about your child to allow us to treat them safely. Please leave any areas you are unsure about blank and the oral healthcare team can discuss these with you. All information will be kept confidential by the people caring for your child. **Please complete the form in BLOCK CAPITALS.**

## Child/ Young Person's details:

First Name:

Surname:

Male: Female: Date of birth: (dd/mm/yyyy)

Ethnicity code (see page 4):

Address:

Town: Postcode:

Telephone/ Mobile:

NHS Number (if known):

## Legal Guardian:

Title: Mr Mrs Ms Miss

First Name:

Surname:

Contact Address:

Contact Number:

Relationship to child/young person:

Mini Mouth Care Matters

## General Medical Practitioner:

Name and address:

Telephone number:

## General Dental Practitioner:

Name and address:

Telephone number:

When did he/she last visit a dentist?

## Social Worker Details:

Does the child/young person have a social worker? Yes: No:

Name:

Contact Number:

E-mail address:

Location:

## School Details:

Name:

Address:

Contact Number:

| Is he/she currently: | Yes | No |
|---|---|---|
| Receiving treatment from a doctor, hospital or clinic? | | |
| Taking any prescribed medicines? (please provide details below) | | |

How does he/she manage with taking medications orally? e.g. tablet form/ liquid form/ self-administers / takes medication with support/ must be crushed covertly within food or other (please provide details below)

| | | |
|---|---|---|
| Carrying a medical warning card? | | |

| Does he/she have any of the following conditions? | Yes | No |
|---|---|---|
| Allergies to any medicines (e.g. penicillin), substances (e.g. latex/rubber or foods)? | | |

Please provide details about their allergies:

| | | |
|---|---|---|
| Hay fever or eczema? | | |
| A learning difficulty, autistic spectrum disorders, ADHD or similar syndromes? If yes, please give further detail below e.g. mild, moderate, severe | | |
| Bronchitis, asthma or other chest condition? | | |
| Fainting attacks, giddiness, blackouts, epilepsy? | | |
| Muscle problems (e.g. myopathy, dystrophy, paralysis)? | | |
| Heart problems (e.g. angina, blood pressure problems or stroke)? | | |
| Diabetes (or does anyone in their family)? | | |
| Neurological (nerve) diseases (e.g. 'neuropathies', Multiple Sclerosis etc.)? | | |
| Bruising or persistent bleeding following injury, tooth extraction or surgery? | | |
| Any infectious diseases (including HIV, hepatitis, TB - tuberculosis)? | | |

Details:

| Does your he/she have: | Yes | No |
|---|---|---|
| Visual impairment? | | |
| Hearing impairment? | | |
| Rheumatic fever, heart murmur or chorea? | | |
| Liver disease (e.g. jaundice, hepatitis)? | | |
| Kidney disease? | | |
| A bad reaction to general or local anaesthetic? | | |
| Treatment that required them to be in hospital? Please give details below | | |
| Any previous surgeries? Please give details below | | |
| Steroid treatment? | | |
| Any other serious illness? | | |

Details:

## Form completed by:

Name:

Relationship to child/young person:

Signature:

Date:

Name of dentist:

Dentist signature:

Date:

| Code | Description |
|---|---|
| A | White - British |
| B | White - Irish |
| C | White - Any other White background |
| D | Mixed - White and Black Caribbean |
| E | Mixed - White and Black African |
| F | Mixed - White and Asian |
| G | Mixed - Any other mixed background |
| H | Asian or Asian British - Indian |
| J | Asian or Asian British - Pakistani |
| K | Asian or Asian British - Bangladeshi |
| L | Asian or Asian British - Any other Asian background |
| M | Black or Black British - Caribbean |
| N | Black or Black British - African |
| P | Black or Black British - Any other Black background |
| R | Other Ethnic Groups - Chinese |
| S | Other Ethnic Groups - Any other ethnic group |
| Z | Not stated |