Child
Medical History Form

Charlbury Dental Practice

Full name:			
Date of birth: / /		**Sex:** Male ☐ Female ☐	
Address:			
		Postcode:	
Tel no:		**Parent/Guardian mob no:**	
Parent/Guardian email:			
Are you happy for us to contact you by: Text ☐ Phone ☐ Email ☐ *(please tick all that apply)*			

Doctor's details:

Doctor's name:	**Tel no:**
Address:	
	Postcode:

Is your child currently:	**Yes**	**No**	**Give details** *(continue overleaf if necessary)*
Receiving treatment from the doctor?	☐	☐	
Taking medication?	☐	☐	

Has your child ever suffered from:	**Yes**	**No**	**Give details** *(continue overleaf if necessary)*
Allergies to medicines?	☐	☐	
Any serious illness?	☐	☐	
Congenital heart condition?	☐	☐	
Any other congenital condition?	☐	☐	

Parent/Guardian signature _____ **Date** _____

Medical history update

Please check that the health information on this form is still correct. If not, amend as necessary or note any changes below.

Date	Any changes	List changes below	Parent/Guardian initials