PLEASE ANSWER EACH OF THE FOLLOWING QUESTIONS

DENTAL HISTORY

Has your child been treated previously at a school dental clinic in Queensland? If **YES,** please give the name of the school where your child was last treated, and the year when he or she left: ***School:*** ***Year:***	Yes	No
Is your child available for treatment before or after school? If **YES,** please indicate the available times:	Yes	No
Is your child receiving treatment from another dentist? If **YES,** please give details:	Yes	No
Is your child attending an orthodontist/dental specialist? If **YES,** please give details:	Yes	No
Please list any problems your child has with his/her teeth or mouth:		

MEDICAL HISTORY

I have confidential medical information about my child that I wish to speak to a dentist about (please tick if appropriate) ☐

DOES HE/SHE HAVE, OR HAS HE/SHE EVER HAD, ANY OF THE FOLLOWING MEDICAL CONDITIONS? (Please tick appropriate box/es)

	Yes	No		Yes	No		Yes	No
Rheumatic fever			High or low blood pressure			Bronchitis or other lung diseases		
Heart complaint			Stroke			Tuberculosis		
Heart valve disorder e.g. murmur			Contact with HIV/AIDS virus			Stomach or digestive condition		
Thyroid disease			Growth disorder			Behavioural condition e.g. ADD		
Cardiac pacemaker			Epilepsy			Diabetes		
Prosthetic or other implant e.g. shunt			Radiation therapy			Kidney disease		
Anaemia, leukaemia or other blood diseases			Steroid therapy			Hepatitis or other liver diseases		
Excessive bleeding			Asthma			Other condition/s (please list below)		

Other condition/s not listed above: .....

Is your child being treated by a doctor at present? If **YES**, please give details:	Yes	No
Is your child taking any tablets or medicines (prescribed or over-the-counter)? If **YES**, please give details:	Yes	No
Does your child normally require antibiotic cover before dental treatment? If **YES**, please give details:	Yes	No
Does your child have any abnormal reactions to local or general aneasthesia? If **YES**, please give details:	Yes	No
Does your child smoke?	Yes	No
Is your child pregnant? (females only)	Yes	No

Please list any drugs or medicines your child is allergic to: .....

Please list any other known allergies your child has e.g. latex: .....

Who is your child's doctor? Name / Address: .....

Phone: .....

I consent to other health professionals being consulted where it will assist in the provison of my child's oral health care, and to information relating to my child's oral health care being used by Queensland Health for evaluation purposes so long as my child's name is not used in any reports or published statistics.	Office use only (Checked by dental practitioner)
Signed *(Parent/Guardian):* ..... Date:	