## **CONFIDENTIAL MEDICAL HISTORY**

Dear Parent. The following is a confidential medical history questionnaire that we ask you to complete. The information it provides is very important so we can be familiar with your child's health and assist us to provide the best care for your child.

Please mark the appropriate answer

Full Name	DOB	/	1
Family Medical Practitioner			
Is your child taking any medication	Yes	No	
List names			
Has your child ever had a reaction or allergy to any medication	Yes	No	
Describe			
Has your child ever had a reaction or allergy to an antibiotic Yes	No		
Describe			
Does your child have a known allergy to Latex, dressings or any metals	Yes	No	
Describe			
Does your child have any known food allergies	Yes	No	
Describe			
Does your child have any known insect sting allergies	Yes	No	
Describe			
Has your child been hospitalised for surgery or emergency care	Yes	No	
List date and describe			
Has your child ever had a reaction or problem with an anaesthetic	Yes	No	
Describe			
Does your child have any learning, behavioural or communication disorders	Yes	No	
Describe			

Does your child have any neurological disorders (e.g. Cerebral Palsy)	Yes	No	
Describe			
Does your child have any sensory disorders (Sight, Hearing)	Yes	No	
Describe			
Does your child have any congenital or acquired heart condition	Yes	No	
Describe			
Does your child or family members have any bleeding disorders	Yes	No	
Describe			
Does your child have a breathing disorder (e.g. Asthma)	Yes	No	
Describe			
Does your child have a history of stomach issues (e.g. reflux)	Yes	No	
Describe			
Does your child have a history of diabetes	Yes	No	
Describe			
Does your child have a history of an endocrine disorder (e.g. thyroid)	Yes	No	
Describe			
Does your child have a history of skin problems (e.g. Eczema)	Yes	No	
Describe			
Has your child been exposed to any blood born viruses (e.g. Hepatitis or HIV)	Yes	No	
	168	NO	
Describe		Vec	NI
Does your child have a history of difficult nursing as an infant		Yes	No
Describe			
Have you or your Partner ever needed dental fillings	Yes	No	
Describe			
Please sign to acknowledge that you have completed this form			
01			
Signature Date			

## THIS FORM WILL BE DESTROYED IMMEDIATELY AFTER STORAGE