54 Anstey Road, Alton
Hampshire GU34 2RE
01420 835 89

www.altondental.co.uk

Confidential Medical History Form

We would like to offer you child the best possible treatment and therefore request that you kindly complete the following questionnaire:

Surname....................................... **First Name...**

Date of Birth:......../......../.............. **Title..**

Address..

...Postcode..

Telephone Numbers:

Home.. **Work / Mob:..**

1: Where did you here about us?

...

2: What is the main reason for your child attending this Practice?

...

MEDICAL DETAILS

Is your Child allergic to anything? If so please name:...

Does you child suffer from any of the following:

Diabetes:	**Y/N...**
Hear Problems:	**Y/N...**
Rheumatic Fever:	**Y/N...**
Blood Pressure: High/Low	**Y/N...**
Lung Problems: Asthma/Bronchitis	**Y/N...**
Excessive Bleeding/Bruising	**Y/N...**
Kidney/Liver Disease eg hepatitis	**Y/N...**

Anything else that we should know about:..

...

Please list any current medications:...

Doctor's name, address, and telephone number:

...
...

SIGNED:..DATE:..