

Cynllun Gwên
Designed to smile



Bwrdd Iechyd Prifysgol
Cardiff a Vale
University Health Board



Medical History Form

(To be completed by person with parental responsibility)

Please complete this form providing as much detail as possible. If you are unsure about any of the questions please contact a member of the dental team using the telephone number below.

Call 02920 687624
for more information

Name of Primary School _____

Class Name/Number _____

Child's Full Name _____

Home Address _____

Postcode _____

Daytime Tel. _____

Child's Date of Birth ____/____/____
Day/Month/Year

Name of Child's Dentist _____

Address of Child's Dentist _____

Does your child have any allergies? Yes No

If yes what is he/she allergic to? _____

Has your child ever been admitted to hospital overnight (i.e. to a bed in a ward) due to:

Allergies? Yes No

Asthma? Yes No

Is your child currently taking part in another clinical trial? Yes No

If yes, please give details: _____

For Community Dental Service use only:

Scheduled for baseline examination? Yes No Planned date of examination:

Received by SEWTU: Received by (initials):

Entered into database: Entered by (initials):

SID: PID: