BEACON LODGE DENTAL PRACTICE
CONFIDENTAL MEDICAL HISTORY FORM.

Title: …….. Surname: …….. First Name: ……

Date of Birth: ……

Address: …….

……

Postcode: ……

Telephone Number: Home: ……Work: ……

Mobile: …….

Email……..

Doctor's surgery: & address: ……

…….....

Phone Number: …….

To ensure we follow safeguarding guidelines if patient is less than 18 years of age we require the following:

School/College attended …….

Is your child known to social services ……Y/N

Who has parental responsibility for your child …….

Who has consent on your behalf if you cannot attend the practice?

Name and relationship to child……

In the event of you/ your child suffering a medical emergency while you are on the practice premises do you give consent to take appropriate action if necessary?

Y/N

Emergency contact name: …….

Contact number: ……..

ARE YOU CURRENTLY

Receiving treatment from a doctor hospital or clinic? Y/N Details: …….....

……..
Taking any prescribed medication? (Including tablets, inhalers, injections, contraceptives and ointments) Y/N
Details ……

…….

…….

…….

…….

Taking any self prescribed medicines or drugs? (Including pain killers, herbal or recreational drugs) Y/N
Details……..

……

Do you carry a Medical Warning Card or Bracelet? Y/N

Details: ……..

Do you smoke tobacco products? Y/N / in the past How many daily…….
Do you chew tobacco products? Y/N / in the past.
Do you Vape? Y/N

Do you drink alcohol? Y/N
Approximately how many units per week ……..
(1 unit is ½ pint of lager, 1 glass of wine or 1 measure of spirit)

Are you Pregnant or Possibly Pregnant? Y/N Due Date ……..

Do you have any allergies? (Include drugs e.g. Penicillin, plasters, latex or food) Y/N

Details: ……

…….

Do you require any assistance or information in an alternative format when visiting the practice due to a condition, disability or sensory loss Y/N

Details ……

Our Dental Chairs have weight limits.
So that we can treat you safely can we ask do you weigh in excess of 21 stone (135kg) Y/N

HAVE YOU EVER HAD ANY OF THE FOLLOWING?	**Y**	**N**	**PLEASE GIVE DETAILS**
Any Heart Problems? (Angina/High or Low Blood pressure /stroke/ Valve disease/ Endocarditis/Heart Surgery)			
Any Chest Condition? (Asthma/COPD/Bronchitis/Other)			
Any Bone or Joint disease? (Arthritis/osteo or inflammatory)			
Take bisphosphonate medication? (e.g. Alendronic acid)			
Take any blood anticlotting medication? (eg Warfarin,clopidogrel)			
Liver disease?			
Kidney or urinary tract disease?			
Diabetes?			
Epilepsy?			
Any Mental Health problems? anxiety/depression)			
Any Neurological Condition? (alzheimers/dementia /other)			

	Y	N	PLEASE GIVE DETAILS
Any serious illness or infectious diseases? (Hepatitis/HIV/Herpes Simplex)			
Any Persistent bleeding or bruising after injury, tooth extraction or surgery?			
Any kind of Cancer? (Chemotherapy/radiotherapy/other treatment)			
Any other treatment that required you to be in hospital?			
Any other disabilities or conditions not listed?			
Do you have a Resuscitation Decision Record in place?			

Patient/Carer/Parent Signature …….Date ……

Dentist Signature …….. ……..Date……..