The Staffordshire Clinic
Dental Surgery

Confidential Medical History Form

Mr Mrs Ms Miss Mast Dr Rev Other

Name:	DOB:	Male Female Other	Pt ID:
Occupation:		NHS Number:	

Address:	or New address:
Postcode:	E- mail:
Phone Numbers : Home:	
Mobile:	**Please tick here if you do not wish to receive email information:**
Work:	

Doctors details: Name of Dr: Dr's Phone number::
Address of Dr Surgery:

Are you:	**NA**	**Yes**	**No**	**Give details and list medication**
Pregnant, trying for a baby, or had a baby recently				**Due date/born:**
Currently receiving treatment from a doctor, hospital or clinic				
Taking any medication for bones **- BISPHOSPHONATES**				
Currently taking any prescribed medicines – please list (e.g. tablets, ointments or inhalers including contraceptives and hormone replacement therapy) You can give us a repeat prescription form to copy if that is easier				**List here:**

Do you have or have you ever suffered from:	**Yes**	**No**	**Give details and list medication**
Rheumatic fever			
Any heart problems, heart surgery, pacemaker, angina or stroke			
Diabetes			
Epilepsy or fainting attacks			
Chronic bronchitis, asthma or other chest condition			
Hepatitis			
Excessive bleeding or bruise easily following injury, tooth extraction or surgery			
High blood pressure			
Arthritis			

Have you ever:	**Yes**	**No**	**Give details and list medication**
Had liver disease, jaundice or kidney disease			
Had brain surgery			
Had your blood refused by the blood transfusion service			
Had a joint replacement or other implant			
Had a bad reaction to a local or general anaesthetic			
Been hospitalised, if 'yes' for what and when			
Received growth hormone treatment before the mid 1980's			
Do you have a close relative (parent, sibling, child, grandparent/child) with Creutzfeldt jakob disease			
What is your average weekly consumption of alcohol in units **(3 units is approx 1 pint of beer/lager or large glass of red wine)**	Ave weekly units:		
Do you smoke - If yes how many per day			How many:
Do you use a vaping device, if yes how many times per day			How many:
Have you ever smoked or chewed tobacco in the past - if yes how long ago			How long ago
Are you **allergic** to any medicines, foods etc			
Do you carry an Epipen for allergies?			
Is there any other information which your dentist may need to know?			

Sign & Date: Signed by self , Parent/ guardian, Other Dentist sign:

One section to be completed at every 6 month exam appointment or new course of treatment:

Pt Name: **DOB:**

Since your last visit: Date today:	Yes	No	Give details
Are your contact details still the same?			
Have you changed, stopped or started any new medications?			
Do you smoke - if yes how many per day?			How many:
Do you use a vaping device – if yes how many per day?			How many:
What is your weekly alcohol consumption	Ave weekly units		
If female: are you pregnant, trying for, or had a baby recently			Give dates:
Sign Signed by: self, parent, guardian/,other	Dentist sign & date:		

Since your last visit: Date today:	Yes	No	Give details
Are your contact details still the same?			
Have you changed, stopped or started any new medications?			
Do you smoke - if yes how many per day?			How many:
Do you use a vaping device – if yes how many per day?			How many:
What is your weekly alcohol consumption	Ave weekly units		
If female: are you pregnant, trying for, or had a baby recently			Give dates:
Sign Signed by: self, parent,guardian/other	Dentist sign & date:		

Since your last visit: Date today:	Yes	No	Give details
Are your contact details still the same?			
Have you changed, stopped or started any new medications?			
Do you smoke - if yes how many per day?			How many:
Do you use a vaping device – if yes how many per day?			How many:
What is your weekly alcohol consumption	Ave weekly units		
If female: are you pregnant, trying for, or had a baby recently			Give dates:
Sign Signed by: self, parent,/guardian, other	Dentist sign & date:		

Since your last visit: Date today:	Yes	No	Give details
Are your contact details still the same?			
Have you changed, stopped or started any new medications?			
Do you smoke - if yes how many per day?			How many:
Do you use a vaping device – if yes how many per day?			How many:
What is your weekly alcohol consumption	Ave weekly units		
If female: are you pregnant, trying for, or had a baby recently			Give dates:
Sign Signed by: self, parent,/guardian, other	Dentist sign & date:		

Since your last visit: Date today:	Yes	No	Give details
Are your contact details still the same?			
Have you changed, stopped or started any new medications?			
Do you smoke - if yes how many per day?			How many:
Do you use a vaping device – if yes how many per day?			How many:
What is your weekly alcohol consumption	Ave weekly units		
If female: are you pregnant, trying for, or had a baby recently			Give dates:
Sign Signed by: self, parent,/guardian, other	Dentist sign & date:		

info@thestaffordshireclinic.co.uk
Irfan H. Khan BDS Jonathan Langley BDS and Associates
Jervis House, Church Street, Uttoxeter ST14 8AF Tel. 01889 562109