MICHAEL SHIPWAY & ASSOCIATES
DENTALCARE CHELTENHAM

MEDICAL HISTORY FORM - CONFIDENTIAL

TITLE:	
FIRST NAME:	
SURNAME:	
DATE OF BIRTH:	**HOME TEL:** **MOBILE TEL:**
HOME ADDRESS:	
POSTCODE:	
EMAIL:	
YOUR DOCTORS NAME (if known):	
DOCTORS SURGERY AND ADDRESS (if known):	
YOUR PREVIOUS DENTISTS NAME AND ADDRESS (if applicable):	
NEXT OF KIN AND EMERGENCY CONTACT DETAILS:	

HABITS			
	Qty		
Smoking (cigarettes/cigars per day)		Do you have a High Sugar Diet?	Y / N
Alcohol Units (per week)			
Additional details			
HEART - DO YOU HAVE ANY OF THE FOLLOWING CONDITIONS?			
Rheumatic fever	Y / N	Heart Murmur	Y / N
High Blood Pressure	Y / N	Angina	Y / N
Heart surgery	Y / N	Thrombosis	Y / N
Pacemaker Fitted	Y / N	Other heart conditions	Y / N
Additional details			
BLOOD – DO YOU HAVE ANY OF THE FOLLOWING CONDITIONS?			
Hepatitis B	Y / N	Anaemia	Y / N
H.I.V.	Y / N	Sickle cell	Y / N
Abnormal Blood Test	Y / N	Haemophilia	Y / N
Other blood conditions	Y / N		
Additional Details			
ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?			
Penicillin	Y / N	Latex Allergy	Y / N
Hay Fever	Y / N	Medicines	Y / N
Anti-Tetanus Serum	Y / N	Aspirin	Y / N
Eczema	Y / N	Other Allergy Conditions	Y / N
General Anaesthetic	Y / N	Local Anaesthetic	Y / N
Additional Details			

MICHAEL SHIPWAY & ASSOCIATES
DENTALCARE CHELTENHAM

WARNINGS – PLEASE ANSWER YES OR NO TO THE FOLLOWING:			
Pregnant or possibly pregnant?	Y / N	Are you able to lie flat?	Y / N
Do you require Antibiotic Cover?	Y / N	Taken steroids within 2 years?	Y / N
Do you have bruising or persistent bleeding?	Y / N	Do you carry a warning card?	Y / N
Currently under Treatment	Y / N	Any recent Hospitalisation's?	Y / N
Anything else the Dentist should know?	Y / N		
Additional Details:			
CHEST - DO YOU HAVE ANY OF THE FOLLOWING CONDITIONS?			
Bronchitis	Y / N	Emphysema	Y / N
Cystic fibrosis	Y / N	Pneumonia	Y / N
Pleurisy	Y / N	Chest surgery	Y / N
Asthmatic	Y / N	Other chest conditions	Y / N
Additional Details:			
MEDICATION LIST: PLEASE LIST ANY MEDICATIONS BELOW			
OTHER – DO YOU HAVE ANY OF THE FOLLOWING CONDITIONS?			
Liver Disease	Y / N	Kidney disease	Y / N
Diabetes	Y / N	Epilepsy	Y / N
Acid Reflux or eating Disorder	Y / N	Hiatus Hernia	Y / N
Bone or joint disease	Y / N	Artificial joint	Y / N
Fainting attacks or blackouts	Y / N	Giddiness	Y / N
Past serious or infectious disease	Y / N	Cancer	Y / N
Additional Details:			

I would like to receive communications such as practice newsletters and details of services and discounts you offer. By ticking this box, you will explicitly be providing consent to the processing. You can withdraw your consent at any time.

☐ Yes ☐ No

Signature:	Date: .....

Michael Shipway & Associates
17 Ormond Terrace, Regent St, Cheltenaham GL50 1HR
Phone: 01242 522161