佛教慈濟基金會澳洲布里斯本聯絡處
Buddhist Compassion Relief Tzu-Chi Foundation Brisbane Australia

inclusive health clinic
OVERCOMING HEALTH INEQUALITY

MEDICAL HISTORY FORM

** It is important to know details about your medical history as these could affect the success of your dental treatment.
** The information you provide is confidential.

Last Name:	Title (eg: Mr/Mrs/Ms/Dr):	Date of Birth:____/____/_____
First Name:	Gender: Male ☐ Female ☐	*ID Checked (IHC Use Only, Staff please Initial)* ☐
Home address: Postal address (If different):		Phone (Home): Phone (Work): Mobile:
Email Address:		Emergency contact person: Name:
I have confidential medical information that I do not wish to write down & I would prefer to speak to a dentist about this (please tick box) ☐		Relationship: Phone:

In which country were you born? (please tick ONE box, and enter name of country if born overseas)
☐Australia ☐ Another Country - Name of Country: Language spoken at home:

Are you Australian Aboriginal or Torres Strait Islander? (please tick ONE box) - ☐ Yes, Aboriginal ☐Yes, Torres Strait Islander ☐No

Do you require an interpreter? YES NO	If YES - What Language?	If an interpreter filled this form, name & NAATI ID:

Do you have a **Medicare Card?** YES NO ◆ Expiry Date: __ / ____
If YES, what is the Number? _ _ _ _ - _ _ _ _ _ - _ ◆ Ref# _

Do you have a **Healthcare or Pensioner Concession Card?** YES NO
If YES – what is the number? _ _ _ _ _ _ _ _ _ ◆ Exp Date: __ / __

Your Medical Practitioner (GP)
Name: | Clinic Name:
Address: | Phone:

			If " Yes", please give details
Are you taking any medications (prescribed or over-the-counter) at present?	NO	YES	
* Any blood thinners, Warfarin (check INR) & bone medications?	NO	YES	
Please list any known allergies (drugs/medicines/food/others):	NO	YES	
Have you had any abnormal reactions to local or general anaesthesia?	NO	YES	
Do you smoke?	NO	YES	
Have you had a joint replacement surgery, prosthetic implant, etc.	NO	YES	
Are you likely to be pregnant at the moment? (Females only)	NO	YES	

DO YOU HAVE NOW, OR HAVE YOU EVER HAD, ANY OF THE FOLLOWING MEDICAL CONDITIONS?

	NO	YES		NO	YES		NO	YES
Asthma	☐	☐	H.I.V / AIDS	☐	☐	Steroid Therapy	☐	☐
Blood diseases (eg. Anaemia, leukaemia)	☐	☐	Rheumatic fever	☐	☐	Thyroid disease	☐	☐
High/Low blood pressure	☐	☐	*Osteoporosis	☐	☐	Stomach or digestive condition	☐	☐
*Diabetes	☐	☐	*Kidney disease	☐	☐	Bronchitis, emphysema or other lung diseases	☐	☐
Epilepsy	☐	☐	*Cancer	☐	☐	Tuberculosis	☐	☐
Prolonged bleeding	☐	☐	Radiation Therapy	☐	☐	Nervous or psychiatric condition	☐	☐
Heart condition	☐	☐	Cardiac pacemaker	☐	☐	Any other conditions, please specify below:	☐	☐
*Hepatitis or other liver disease	☐	☐	Stroke	☐	☐			

* Do you normally require antibiotic cover before dental treatment?	NO	YES	Any FLU-LIKE symptoms TODAY?	NO	YES

PLEASE LIST ANY CONCERNS OR PROBLEMS THAT YOU HAVE WITH YOUR TEETH OR MOUTH:

I consent to health professionals who have treated me exchanging such information about me as may be required to assist in providing oral and general health care to me. I also consent to information that has been collected by Tzu Chi Foundation, being used to check and assess health services I have received and how those services have been used, so long as my name is not used in any reports or published statistics.

Office use only (Clinician Initial)

Your/ Guardian' s signature: Date:____/____/_____