

ADULT HEALTH CHECK 15-19 years female



Practice name _____

First name _____ Surname _____

Date of Birth: _____

Address: _____

Suburb: _____

State: _____ Postcode: _____

Phone: (H) _____

Mobile: _____

Medicare number: _____

Indigenous status: Aboriginal Torres Strait Islander Both Neither Other

Has client had a Health Check (710) in the past 24 months? No If yes, NOT ELIGIBLE

The process and benefits of a health check have been explained and consent has been given to proceed. Yes

Doctors name: _____ Practice address: _____

Phone: Business hours _____

After Hours emergency: _____

BACKGROUND INFORMATION

Current Health: Client says current health is _____

Personal Medical History:

(hospitalisations, serious illness, etc) _____

Family Medical History:

Diabetes Yes No **Heart disease** Yes No

Other family medical history: _____

Social History: : (education, employment, living conditions, etc) _____

Immunisation status up to date?

Yes No

Comment:.....

.....

Childhood immunisation complete, dTpa @ 15yrs and 50 yr, Gardasil x 3 doses (12 -26yrs females only), fluvax annually, pneumovax every 5 yrs for 50 + and/or all with chronic disease)

Any known allergies? Yes No If yes, list: _____

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PHYSICAL EXAMINATION

Height: _____ cm Body mass index: _____
Weight: _____ kgs Comment: _____
Blood sugar level _____
Urinalysis: _____

Hearing

Are you concerned about your hearing? Yes No

If yes, describe _____

Right Ear (otoscope) Normal Red Retracted Perforated Discharge
Left Ear (otoscope) Normal Red Retracted Perforated Discharge

Eyes

Visual acuity : Right eye /6 Left eye /6 Glasses? Yes No
Sclera, eyelids, eyelashes: Healthy Other: _____

Cardiovascular:

Pulse: _____ Regular Yes No

Blood pressure: /

Do you take any medications regularly? Yes No If yes, list: _____

General

Skin Integrity Healthy Sores / Bites Scars / Bruises Rash
 Itchy Other _____

Limbs Healthy Swollen joints Sore joint(s) Other: _____

Movement Healthy Abnormal gait: _____

Head and Face Healthy Facial Anomalies: _____

Anaemia? (check palms, conjunctiva of eyes, tongue): Healthy Pale

Comments _____

Sexual and Reproductive Health

Do you have any problem with your periods? Normal Pain Very heavy Irregular

Have you become sexually active? Yes No

If yes, do you have a regular sexual partner? Not regular Yes No

Do you use any contraception or protection? Yes No

Have you ever been tested for sexually transmitted diseases? Yes No
Comment: _____

Do you know about PAP smears and have you had one? Know about it: Yes No
Had one: Yes No

Do you know how, when and why to check your breasts for lumps? Yes No

Have you ever been pregnant? Yes No

Comment: _____

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Oral Health

Access to toothbrush and toothpaste?

Yes No

Every person needs their own personal toothbrush. This should be regularly replaced.

Frequency of brushing?

1-2 x day
 Sometimes
 Never

Teeth should be brushed twice a day: once in the morning and before bed at night

Do you use dental floss?

Yes No

Teeth should be flossed daily to prevent tooth decay in "hard to clean" places.

Have you been to the dentist in past 12 months?

Yes No

Regular visits to dentist help keep teeth clean and decay free.

On examination -

Normal
 Decay
 Other problem

Refer to dentist as necessary.

Smoking, drinking and drugs

Do you smoke?

Yes No

If yes, have you tried to stop?
Stage of Change: _____

Do you drink alcohol?

Yes No

Recommended maximum daily intake of alcohol discussed.

Have you used any other drugs?

Yes No

Refer to counselor as required

Exercise

Do you exercise up to 30 minutes on most days?

Yes No

Recommend 30 minutes of moderate physical activity on most days.

Sleep

How many hours sleep do you get in total each day? _____

8-9 hours is recommended at this age.

Nutrition

Do you regularly eat breakfast, lunch and dinner?

Yes No

Recommend healthy diet including fruit, vegetables, dairy, protein from meat, chicken or fish and high fibre.

How often do you eat take-away food?

every day
 3 x week
 not often

Take away food is high in fats and not very nutritious. Limit take-away food.

How often do you drink juice, cordial or soft drink?

Every day
 Sometimes
 Not often

Recommend limiting sugar drinks to special occasions and provide water to drink instead.

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EMOTIONAL WELLBEING

Are your friends a big influence on the things you do? Yes No

In the last month have you felt.....

Happy in yourself? Yes No

So sad nothing could make you happy? Yes No

So worried that you felt sick? Yes No

Like you wanted to hurt yourself? Yes No

So angry you couldn't walk away and cool down? Yes No

Topics initiated by client

Are there any topics the client would like to talk about? Yes No

If yes, describe _____

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CLIENT SUMMARY

Risks identified:

- 1.
- 2.
- 3.

STRATEGY FOR GOOD HEALTH

Visit GP every two years for health check.
Follow dietary and exercise advice as discussed.
Brush teeth twice a day and floss.
Attend appointments as arranged.

PERSONAL GOAL

_____ has identified the most important risk to work on

as: _____

and plans to _____

_____.

APPOINTMENTS / TESTS

List required appointments or tests here:

Arrangements made? Yes No

Arrangements made? Yes No

Dr _____ has discussed a strategy for improving my health based on the risk factors identified. Follow up appointments and any additional tests required have been explained to me.

Assisted by: _____ RN / AHW / _____

Completed by: Dr _____

Date completed: _____

Copy of the Health Strategy offered to the client? Yes No

Review date: _____ (minimum 24 months) Medicare item # 710