

ADULT HEALTH CHECK 55+ years male



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 Assessment (704 / 706 / 710) in the past 12 months? No
If yes, NOT ELIGIBLE.

The process and benefits of a health assessment 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) _____

Family Medical History:
Diabetes Yes No **Heart disease** Yes No
Other family medical history: _____

Immunisation

Fluvax (every year)	<input type="checkbox"/> Yes <input type="checkbox"/> No
ADT (at 50 years or now)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
Pneumovax (every 5yrs)	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, next due: _____

Medications:

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

Does client use a Webster pack? Yes No

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PHYSICAL EXAMINATION

Height: _____ cm Body mass index: _____

Weight: _____ kgs BGL: _____

Cardiovascular:

Pulse: _____ Regular? Yes No Blood pressure: / mmHg

Pathology

Urinalysis	Results:
UEC / FBC / Fasting lipids / Blood sugar	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not indicated
Faecal occult blood test done?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not indicated
PSA done?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not indicated

Hearing

Are you worried about your hearing? Yes No
If yes, describe _____

Right Ear (otoscope)	<input type="checkbox"/> Normal	<input type="checkbox"/> Waxy	<input type="checkbox"/> Perforated	<input type="checkbox"/> Discharge
Left Ear (otoscope)	<input type="checkbox"/> Normal	<input type="checkbox"/> Waxy	<input type="checkbox"/> Perforated	<input type="checkbox"/> Discharge

Vision

Do you wear glasses? Yes No
Eyes last checked by optometrist: in last 12 months more than a year ago
Have you had any eye surgery? Yes No
If yes, please explain: _____
Visual acuity- with glasses if worn: Right - / 6 Left - / 6
Sclera, eyelids, eyelashes NAD Pterygium Other _____

General

Skin Integrity	<input type="checkbox"/> Healthy	<input type="checkbox"/> Sores / Bites	<input type="checkbox"/> Scars / Bruises	<input type="checkbox"/> Rash
	<input type="checkbox"/> Itchy	<input type="checkbox"/> Other _____		
Limbs	<input type="checkbox"/> Healthy	<input type="checkbox"/> Swollen joints	<input type="checkbox"/> Sore joint(s)	<input type="checkbox"/> Other: _____
Movement	<input type="checkbox"/> Healthy	<input type="checkbox"/> Abnormal gait: _____		
Head and Face	<input type="checkbox"/> Healthy	<input type="checkbox"/> Facial Anomalies: _____		

Mens Health

Do you have any trouble passing urine? Yes No
If yes, explain _____

Is there any blood on the paper after a bowel movement? Yes No

Do you have any erection problems? Yes No

Any topic client wants to talk about? Yes No

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Oral Health

How often do you brush your teeth? 1-2 x day Sometimes Rarely
 Seen a dentist in the past 12 months? Yes No
 Oral visual exam: Healthy Decay Dentures Gums
 If client has dentures, do they fit? Yes No Comment _____

Nutrition

Do you eat breakfast, lunch and dinner? Yes No
 Can you prepare and cook food? Yes No
 Do you have any problems eating? Yes No
 If yes, explain _____

Smoking and Alcohol

Do you smoke? Yes No
 Do you drink alcohol? Yes No
 Stage of Change: _____
 Recommended maximum daily intake of alcohol discussed.

Social Health / Home

How many people live with you? Too many Enough Not enough

Do you look after someone else? Yes No

Does anyone look after you? Yes No

Do you get help from any community services? Yes No If yes, explain: _____

What regular social outlets do you have? _____

Do all the things in your house work? Can you get them fixed?

Stove:	Water:	Telephone:	Lights:	Toilet:	Heating
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

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Activities of Daily Living

Can you wash and get dressed by yourself? Yes No

Can you go to the shops/supermarket/hunt/collect bush foods? Yes No

Have you fallen over lately? Yes No

Are you OK for moving around and getting up and down from the ground? Yes No

Do you need help with anything else? Yes No

How do you get around? _____

Mental Health

(Does the patient know who they are, where they are and other things that should be common knowledge for them?) Yes No

Are you sad or worried a lot of the time? Yes No

Are you sleeping OK? Yes No

Is there anything you want to talk about? Yes No

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CLIENT SUMMARY

Risks identified:

- 1.
- 2.
- 3.

STRATEGY FOR GOOD HEALTH

Visit GP every year for a health assessment.
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: _____

Completed by: Dr _____

Date completed: _____

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

Review date: _____ (minimum 12 months)

Medicare item # 704 / 706