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Health Check 15+ years

Medicare Item No. 228, 715, 701, 703, 705, 707, 10987

Facility: ______________________

(Affix identification label here)

URN:

Family name:

Given name(s):

Address:

Date of birth: Sex: ☐ M ☐ F

Patient's actual age:

Indigenous status: ☐ Aboriginal only ☐ Torres Strait Islander only ☐ Aboriginal and Torres Strait Islander ☐ Neither Aboriginal nor Torres Strait Islander ☐ Not stated/unknown

Patient's signature (health check consent): Date:

Have all the benefits, risks, outcomes and results of this health assessment been discussed and explained to the patient by the clinician? ☐ Yes ◯ No

Legend: ◯ Indicates a health risk requiring brief intervention, follow up or action. For support see the Chronic Conditions Manual

DO NOT WRITE IN THIS BINDING MARGIN

Family History

Medical History

Current problems/ concerns

Allergies

Immunisation status

Has the patient had all age related eligible vaccines? ☐ Yes ◯ No

Vaccines due:

Initial Date

HEALTH CHECK 15+ YEARS

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Family name:	Given name(s):	URN:

Body measurements

Weight	kg	Any weight loss without trying (> 55 years)?	☐ No	○ Yes	Date / Initial
Height	cm	BMI: kg/m²	☐ 18.5–24.9	○ Other	
Waist	cm	☐ < 80 cm (female) ☐ < 94 cm (male) ○ Other	Waist-to-height ratio (wt/ht)	☐ 0.4–0.49	○ Other

Clinical measurements

Any shortness of breath?	☐ No	○ Yes	
Heart rate	______ bpm	☐ 60–100	○ Other
Blood pressure	___ / ___	☐ ≤ 130/85	○ Other

For all Aboriginal and Torres Strait Islander people aged 30–79 years OR those aged 45–79 years OR those with diabetes aged 35–79 years use Australian cardiovascular disease risk calculator in Chronic Conditions Manual **to assess CVD risk**

CVD risk score	☐ Low < 5%	○ Intermediate 5–10%	○ High > 10%	Initial / Date

Cognition and recall

Do you have any concerns about your memory or thinking?	☐ No	○ Yes	
Is anyone in your family worried about your memory or thinking?	☐ No	○ Yes	Initial / Date

Continence elimination

Women > 25 years (or earlier for those who have given birth) and males > 55 years

Does the person have any urine or bowel leakage?	☐ No	○ Yes	
Does the person pass urine frequently?	☐ No	○ Yes	
Does the person have any difficulty passing urine?	☐ No	○ Yes	
Does the person have any problems with constipation or faecal loss?	☐ No	○ Yes	Initial / Date

Domestic and family violence

Is the person exposed to violence?	☐ No	○ Yes	Initial / Date

Skin

Is the person concerned about any aspects of or changes to their skin? Describe	☐ No	○ Yes ______	Initial / Date

Ears and hearing

Does patient have any difficulty hearing, ear pain or discharge?	☐ No (skip section)	○ Yes (assess below)	
Otoscopy (describe)	☐ Clean	○ Other ______	
Tympanometry (describe)	☐ Type A	○ Other ______	
Audiometry (describe)	☐ Pass	○ Fail ______	Initial / Date

Eyes examination

Does patient have any problems with vision (± glasses or contacts)	☐ No	○ Yes	
Any history of eye surgery?	☐ No	○ Yes	
Are things blurry when held in their hands or far away?	☐ No	○ Yes	
Any inturned eyelash touching the eyeball or evidence of being plucked?	☐ No	○ Yes	
Does the person have diabetes or hypertension?	☐ No	○ Yes	Date

Perform following procedures if 'Yes' to any above — Initial

Eye appearance	☐ Normal	○ Other	
Near vision test	☐ Normal	○ Other	
Eye movement	☐ Normal	○ Other	
Visual acuity (with prescription glasses or contact lenses)	Left: /	Right: /	

Functional capacity and safety (> 50 years)

Is the person able to care for themselves?	☐ Yes	○ No	
Has the person had any falls in the last 3 months?	☐ No	○ Yes	Date
Can the person manage their own medicines?	☐ Yes	○ No	
Does the person have anyone to help them?	☐ Yes	○ No	Initial

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Queensland Government

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Family name:

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Address:

Date of birth: Sex: ☐ M ☐ F

Nutrition

Question			
What did the person eat and drink yesterday?	☐ Adequate	○ Other	Date
Is the person always able to access food?	☐ Yes	○ No	
How many meals did the person eat yesterday? **(55+)**	☐ 2 – 3	○ Other	Initial

Oral health

Question			
How often does the person brush their teeth?	☐ Twice daily	○ Other	Date
Has the person had toothache or bleeding gums in the last 4 weeks?	☐ No	○ Yes	
Has the person had a dental check in the last 12 months?	☐ Yes	○ No	Initial

Pathology

Aboriginal and Torres Strait Islander people > 15 years annually and all others from > 45 years opportunistically. Take pathology and request the following on form:

Venous blood	○ Glucose ○ Lipid profile ○ Creatinine ○ TPGE ○ HIV antibodies–serology ○ HBsAg, anti-HBs, anti-HBc and anti-HBc IgM (if no evidence of hepatits serology)	
Urine	○ Urine PCR for chlamydia, gonorrhoea and trichomoniasis. If first catch mid-stream urine: +ve for protein then ○ Albumin creatinine ratio. If +ve for nitrites then ○ MCS	Date
Faeces **(50–74)**	Has person received and used the National Bowel Cancer Screening Program kit? ☐ Yes ○ NO - perform faecal occult blood test (FOBT)	Initial

Physical activity

Question				
Was the person physically active for 150 – 300 minutes in the last week?	☐ Yes	○ No	Initial	Date

Reproductive health

Question				
Has the woman noticed any recent breast changes?	☐ No	○ Yes	☐ N/A	
Has the woman had a breast screen in last 2 years? **(40+)**	☐ Yes	○ No	☐ N/A	
Has the woman had any abnormal vaginal bleeding, discharge or lower abdominal pain?	☐ No	○ Yes	☐ N/A	
Has the woman had cervical screening in the last 5 years? **(25+)**	☐ Yes	○ No	☐ N/A	
Has the man noted any changes to testes?	☐ No	○ Yes	☐ N/A	
Has the man had any penile discharge or dysfunction?	☐ No	○ Yes	☐ N/A	Date
Has the man's father or brother been diagnosed with prostate cancer? **(40 – 69)**	☐ No	○ Yes	☐ N/A	Initial

Alcohol, tobacco and other drugs

Question			
Does the person smoke?	☐ No (skip to alcohol questions)	○ Yes	
Minutes after waking to having first cigarette?	○ < 30 mins (high dependence)	☐ > 30 mins	
Number of cigarettes per day?	○ > 10/day (high dependence)	☐ < 10/day	
Any cravings or withdrawal symptoms in previous quit attempts?	☐ No	○ Yes	
Does the person drink alcohol or use other drugs?	☐ No (skip to next section)	○ Yes	
Has the person ever felt like cutting down drinking or drug use?	☐ No	○ Yes	
Have others voiced their concerns about their drinking or drug use?	☐ No	○ Yes	
Have they felt worried about their drinking or drug use?	☐ No	○ Yes	Date
Have they ever had a drink or used drugs first thing in the morning to steady their nerves or to get rid of a hangover?	☐ No	○ Yes	Initial

Social-emotional wellbeing

Tally responses: (1) Not at all (2) Several days (3) More than half the days (4) Nearly every day

Date

Over the last 2 weeks:

How often did you have little interest or fun in doing things?

How often did you feel hopeless, down in the dumps, sad or slack?

How often did you feel nervous, anxious or on edge?

How often were you not able to stop worrying about things?

Tally first 2 questions: ☐ 1 ☐ 2 ○ ≥ 3

Tally second 2 questions: ☐ 1 ☐ 2 ○ ≥ 3

Initial

If score ≥ 3 for first 2 questions OR second 2 questions then perform SDQ OR DASS. For a teenager perform HEADDS assessment. Refer

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Family name:	Given name(s):	URN:

Advance care planning

Ask yourself: "Given all I know about this person's health and behaviours, would I be surprised if they were to pass away in the next 6–12 months?"	☐ Yes	○ No (perform ACP)

Note any required actions and transfer to Care Management Plan

Medicare

Medicare item being claimed?	☐ Yes	○ No
All benefits, risks, outcomes and results of this health assessment discussed and explained to person by clinician?	☐ Yes	○ No (can not claim Medicare)
Written or photocopied feedback of action plan provided to person?	☐ Yes	○ No (can not claim Medicare)
Medicare claim form signed by person?	☐ Yes	○ No (can not claim Medicare)

Doctor name	Signature	Date

Signature log

Signature	Name	Date	Initial

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