# Health Check

## 55+ Years

**Medicare Item No. 715**

### Legend:
- Indicates a health risk that requires brief intervention, follow up or action.

### Patient's actual age:

### Indigenous status:
- Aboriginal but not Torres Strait Islander origin
- Torres Strait Islander but not Aboriginal origin
- Both Aboriginal and Torres Strait Islander origin
- Neither Aboriginal or Torres Strait Islander origin
- Not stated / unknown

### Has the client had a health check in the last 12 months? [ ] Yes [ ] No

### Has the client been advised of the process and benefits of health check? [ ] Yes [ ] No

### Client's signature (consent for health check):

### Date:

## Medical History

### Family history:

### Medical history:

### Current problems / concerns:

## Examination

*MO’s note: examination requirements on following pages*:

## Medications:

## Immunisations:

<table>
<thead>
<tr>
<th>Pneumococcal</th>
<th>Yes</th>
<th>No</th>
<th>Tetanus</th>
<th>Yes</th>
<th>No</th>
<th>Other</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

## Additional health check items to be included (co-morbidities / other care items due)

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Contact: CIM@health.qld.gov.au
<table>
<thead>
<tr>
<th><strong>Body measurements</strong></th>
<th><strong>Print name:</strong></th>
<th><strong>Signature:</strong></th>
<th><strong>Date:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Weight</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>kg</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Waist</td>
<td>mm</td>
<td></td>
<td>Low risk</td>
</tr>
<tr>
<td>Height</td>
<td>cm</td>
<td>BMI</td>
<td>Underweight</td>
</tr>
<tr>
<td>Any weight loss without trying?</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Clinical measurements</strong></th>
<th><strong>Print name:</strong></th>
<th><strong>Signature:</strong></th>
<th><strong>Date:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Any shortness of breath / wind?</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Heart rate</td>
<td>Normal</td>
<td>Abnormal</td>
<td></td>
</tr>
<tr>
<td>Heart rhythm</td>
<td>Regular</td>
<td>Irregular</td>
<td></td>
</tr>
<tr>
<td>Blood pressure</td>
<td>mm / mm</td>
<td>Healthy</td>
<td>Raised</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Skin</strong></th>
<th><strong>Print name:</strong></th>
<th><strong>Signature:</strong></th>
<th><strong>Date:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Any changes to birthmarks, moles or other skin marks?</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Describe skin</td>
<td>Healthy</td>
<td>Intact</td>
<td>Sores</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Hearing</strong></th>
<th><strong>Print name:</strong></th>
<th><strong>Signature:</strong></th>
<th><strong>Date:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you have any difficulty hearing?</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Any pain / discharge from ears?</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Otoscopy Left:</td>
<td>Pass</td>
<td>Refer</td>
<td></td>
</tr>
<tr>
<td>Right:</td>
<td>Pass</td>
<td>Refer</td>
<td></td>
</tr>
<tr>
<td>Whisper test / audiometry Left:</td>
<td>Pass</td>
<td>Refer</td>
<td></td>
</tr>
<tr>
<td>Right:</td>
<td>Pass</td>
<td>Refer</td>
<td></td>
</tr>
<tr>
<td>Tympanometry Left:</td>
<td>Pass (Type A)</td>
<td>Refer (Type B or C)</td>
<td></td>
</tr>
<tr>
<td>Right:</td>
<td>Pass (Type A)</td>
<td>Refer (Type B or C)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Eyes examination</strong></th>
<th><strong>Print name:</strong></th>
<th><strong>Signature:</strong></th>
<th><strong>Date:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Lens</em> Left:</td>
<td>Healthy</td>
<td>Abnormal</td>
<td></td>
</tr>
<tr>
<td>Right:</td>
<td>Healthy</td>
<td>Abnormal</td>
<td></td>
</tr>
<tr>
<td>Conjunctiva Left:</td>
<td>Healthy</td>
<td>Abnormal</td>
<td></td>
</tr>
<tr>
<td>Right:</td>
<td>Healthy</td>
<td>Abnormal</td>
<td></td>
</tr>
<tr>
<td>Cornea Left:</td>
<td>Healthy</td>
<td>Abnormal</td>
<td></td>
</tr>
<tr>
<td>Right:</td>
<td>Healthy</td>
<td>Abnormal</td>
<td></td>
</tr>
<tr>
<td>Did you grow up in a desert environment?</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Trachoma check - any inverted lashes?</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Can you see things close up?</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Visual acuity (with prescription glasses if worn) Left:</td>
<td>/ 6</td>
<td>Right:</td>
<td>/ 6</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Women's health</strong></th>
<th><strong>Print name:</strong></th>
<th><strong>Signature:</strong></th>
<th><strong>Date:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast changes?</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Breast screen in last 2 years?</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Pap smear in last 2 years?</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Abnormal vaginal bleeding or discharge?</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Lower abdominal (underbelt) pain?</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Any urine leaking during cough / sneeze / moving?</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Any increased urinary frequency at night?</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Any problems with faecal loss?</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Men's health</strong></th>
<th><strong>Print name:</strong></th>
<th><strong>Signature:</strong></th>
<th><strong>Date:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Any sexual dysfunction?</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Any difficulty passing urine, urine frequency, dribbling or a feeling that you have not completely emptied your bladder?</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Any problems with faecal loss?</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>
### Pathology

#### Urinalysis
- **Protein:**
  - Neg/trace
  - 1+
  - 2+
  - 3+
  - 4+
- **Nitrates:**
  - Positive
  - Negative
- **ACR:**
  - Yes
  - No
- **MSU:**
  - Yes
  - No
- **Venous blood collected**
  - Fasting
  - Random
- **Tc/Tg/LDL/HDL**
- **Glucose**
- **Syphilis**

#### Oral health
- **Have you had a dental check up in the last 12 months?**
  - Yes
  - No
- **Any difficulty chewing?**
  - Yes
  - No
- **Any toothaches or bleeding gums in the last 4 weeks?**
  - Yes
  - No
- **Oral examination of teeth:**
  - Healthy
  - Decay
  - Malalignment
  - No exam
- **Oral examination of gums:**
  - Healthy
  - Bleeding
  - Swelling
  - No exam

### Nutrition
- **Number of serves of fruit yesterday**
  - Enough
  - Not enough
- **Number of serves of vegetables yesterday**
  - Enough
  - Not enough
- **Number of serves of sugary drinks yesterday**
- **How many meals did you eat yesterday?**
  - 0
  - 1
  - 2
  - 3
  - 4+
- **If hungry, are you always able to get some food?**
  - Yes
  - No

### Physical activity
- **Did you do any physical activity in the last week?**
  - Yes
  - No
- **How many days were you active?**
- **Were you active for 30 minutes or more at a time?**
  - Yes
  - No
- **Level of physical activity**
  - Enough
  - Not enough

### Alcohol, tobacco and other drugs
- **Do you smoke?**
  - Daily
  - Weekly
  - Irregularly
  - Ex-smoker
  - Never
- **When did you last drink alcohol?**
  - Within last week
  - Last month
  - Over a month ago
  - Never
- **What do you usually drink?**
- **Rate alcohol consumption**
  - Never
  - Low risk
  - High risk
- **Do you use any drugs / substances?**
  - Daily
  - Weekly
  - Irregularly
  - Ex-user
  - Never
- **Do alcohol / drugs / substances cause problems in your life?**
  - Yes
  - No

### Functional capacity and safety
- **Are you able to care for yourself?**
  - Yes
  - No
- **Any falls in the past 3 months?**
  - Yes
  - No
- **Can you manage your own medicines?**
  - Yes
  - No
- **Do you have anyone to help you?**
  - Yes
  - No
- **Is your carer paid?**
  - Yes
  - No
- **Are you a carer of another person?**
  - Yes
  - No
- **Are you exposed to violence?**
  - Yes
  - No

### Cognition and recall
- **Name 3 items**
  - (record responses, continue to next question)
- **Do you know the name of this place?**
  - Correct
  - Incorrect
- **What time of the year is it now?**
  - Correct
  - Incorrect
- **Repeat the 3 items from before**
  - Correct
  - Partially correct
  - Incorrect
## Social emotional well-being

<table>
<thead>
<tr>
<th>In the last 4 weeks have you felt:</th>
<th>All the time</th>
<th>Most of the time</th>
<th>Some of the time</th>
<th>A little of the time</th>
<th>Not at all</th>
<th>Don’t know</th>
<th>No response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Happy in yourself?</td>
<td></td>
<td></td>
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<tr>
<td>So sad that nothing could cheer you up?</td>
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<tr>
<td>Nervous?</td>
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<tr>
<td>Restless and jumpy?</td>
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<tr>
<td>Everything was an effort?</td>
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<tr>
<td>Angry with yourself or others?</td>
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<tr>
<td>Like you might hurt yourself?</td>
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</tbody>
</table>

Health worker / carer: do you think this person has changed his / her behaviour or, is there anything about him / her that makes your concerned about their mental health?
- Yes - urgent referral
- Yes - referral required
- No
- Don’t know

## Action plan for good health

<table>
<thead>
<tr>
<th>Risks identified</th>
<th>Referrals / actions</th>
<th>Initial</th>
<th>Date</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

## Actions to be taken by patient / carer

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All risks, outcomes and results discussed and explained to client / carer by MO?
- Yes
- No

Medical Officer signature: Date:

Written feedback report provided to client?
- Yes
- No

Carer / parent signature: Date:

Care plans / follow up assigned on PHCIS?
- Yes
- No

Medicare Item No. 715 Aboriginal and Torres Strait Islander Child Health Check (all Item 715 can be claimed every 9 months if items complete)
- Yes
- No

Date: