Queensland Government

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

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

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HEALTH CHECK 15+ YEARS

Family name:	Given name(s):	URN:

Body measurements

Weight ____ kg

Height ____ cm

Waist ____ cm

Any weight loss without trying (> 55 years)? ☐ No ○ Yes Date Initial

BMI ____ kg/m² ☐ 18.5–24.9 ○ Other

☐ < 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 Initial

Perform following procedures if 'Yes' to any above

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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HEALTH CHECK 15+ YEARS

Nutrition

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

Oral health

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	Initial
Has the person had a dental check in the last 12 months?	☐ Yes	○ No	

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
Faeces **(50–74)**	Has person received and used the National Bowel Cancer Screening Program kit? ☐ Yes ○ NO - perform faecal occult blood test (FOBT)

Date

Initial

Physical activity

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

Reproductive health

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
Has the man's father or brother been diagnosed with prostate cancer? **(40 – 69)**	☐ No	○ Yes	☐ N/A

Date

Initial

Alcohol, tobacco and other drugs

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
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

Date

Initial

Social-emotional wellbeing

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

Date

Initial

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

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

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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