



HEALTH ASSESSMENT

Aged 75+ Aboriginal & Torres Strait Islander 55+
(to be conducted by the patient's usual GP)

Practice Record

All Practice Item 700 Home Item 702 Aboriginal & Torres Strait Islander Practice Item 704 Home Item 706

PATIENT NAME _____

DOB _____ Male / Female

Name & contact details of carer _____

Medical Practitioner:

Medical record/file number:

Is this patient a carer? Y / N

This is the only health assessment the patient has undertaken in the last 12 months Y / N

This is a review of a Health Assessment undertaken / / _____

Health Assessment at Practice

Home Visit

CURRENT HEALTH / RELEVANT FAMILY HISTORY

1 Ask the patient 'in general, would you say your health is?'
 Excellent
 Very good
 Good
 Fair
 Poor

2 Current health problems / relevant family history

COMMUNITY / ALLIED HEALTH SERVICES

3 Ask the patient 'Are you seeing or have you seen any other GP/specialist/other health worker/service provider in the last 6 months?'
 eg
 Aboriginal health worker
 Audiologist
 Community nurse
 Continence adviser
 Daycare worker
 Dentist
 Dietitian
 Education provider
 Home help
 Home maintenance
 Meals on wheels
 Occupational therapist
 Optometrist
 Orthoptist
 Orthotist
 Personal carer
 Pharmacist
 Physiotherapist
 Podiatrist
 Probation officer
 Prosthetist
 Psychologist
 Registered nurse
 Respite carer
 Social worker
 Specialist
 Speech pathologist
 Transport provider
 Other _____

other services/specialists in last 6 months	reason
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

SMOKING / ALCOHOL

- 4 Smoking**
- Never smoked
- Has quit smoking (when)
- Currently smokes
- Wishes to quit

Comments

5 Alcohol Consumption

Comments

Consider AUDIT, CAGE or other scales Y / N

PHYSICAL ACTIVITY

- 6 Do you exercise at least 30 minutes a day, most days** Y / N

EXAMINATION

- 7 Weight** _____ kg
- 8 Height** _____ m
- 9 BMI** _____
- 10 BP/Pulses**
- Systolic BP _____ mm/Hg
- Diastolic BP _____ mm/Hg
- Pulse regular
- Pulse irregular
- Pulse rate _____

Comments

Consider check for postural hypotension Y / N

GENERAL PHYSICAL EXAMINATION

11 Comments

OTHER RELEVANT PHYSICAL EXAMINATION

12 Oral Health

Comments eg teeth, gums, dentures

- 13 Feet** Problems with one or both feet? Y / N

Comments

- 14 Vision** Acuity (with glasses) _____

Comments

- 15 Hearing**
- a Whisper test Heard
Not heard
- Comments
-

- b Hearing aid N/A
Adequate
Poor
- c Check ear canals Normal
Abnormal

- 16 Fit to drive** Y / N
- Comments
-

Refer AustRoads Guidelines

NUTRITION

17

Nutrition

These questions may not apply to all eg those with particular conditions or lifestyles

- | | yes | no | score |
|--|-----|----|--------------------------|
| Do you have an illness or condition that made you change the kind and/or amount of food you eat? | 2 | 0 | <input type="checkbox"/> |
| Do you eat at least 3 meals per day? | 0 | 3 | <input type="checkbox"/> |
| Do you eat fruit or vegetables most days? | 0 | 2 | <input type="checkbox"/> |
| Do you eat dairy products most days? | 0 | 2 | <input type="checkbox"/> |
| Do you have 3 or more glasses of beer, wine or spirits almost every day? | 3 | 0 | <input type="checkbox"/> |
| Do you have 6-8 cups of fluids most days? | 0 | 1 | <input type="checkbox"/> |
| Do you have teeth, mouth or swallowing problems that make it hard to eat? | 4 | 0 | <input type="checkbox"/> |
| Do you always have enough money to buy food? | 0 | 3 | <input type="checkbox"/> |
| Do you eat alone most of the time? | 2 | 0 | <input type="checkbox"/> |
| Do you take 3 or more prescribed or over the counter medicines every day? | 3 | 0 | <input type="checkbox"/> |
| Without wanting to, have you lost or gained 5kg in the last 6 months? | 2 | 0 | <input type="checkbox"/> |
| Are you always able to shop, cook and/or feed yourself? | 0 | 2 | <input type="checkbox"/> |

Total score

0-3 good, 4-5 moderate, 6-29 high risk

Comments

MENTAL STATUS

18 Any problems with memory, thinking, planning, motivation?

Consider Folstein Mini-Mental State Examination Y / N

INDEPENDENCE / SOCIAL SUPPORT

19 Are you living

- Alone
As a couple
With others

Comments

20 Social support

- a During the last 4 weeks, was someone available to help you if you needed and wanted help? For example if you:
- Felt very nervous, lonely or blue
 - Got sick and had to stay in bed
 - Needed someone to talk to
 - Needed help with daily chores
 - Needed help just taking care of yourself
- Yes as much as I wanted
Yes, quite a bit
Yes, some
Yes, a little
No, not at all
- b Do you have a carer? Y / N
- c Are you responsible for the care of someone else? If yes: who/relationship Y / N

Consider Dukes Scale

Y / N

MOOD / SLEEP

21 Mood (affect)

- a During the last 4 weeks how much have you been bothered by emotional problems such as feeling anxious, depressed, irritable, downhearted or blue?
- Not at all
Slightly
Moderately
Quite a bit
Extremely

b Have you had any difficulty sleeping? Y / N

Details:

Consider Geriatric Depression Scale

Y / N

Comment

CONTINENCE

- 22 Contenance**
- Leaking urine? Never
Sometimes
Often
- Is this related to coughing
or sneezing? Y / N
- Faecal soiling/change of
bowel habit Never
Sometimes
Often
- Comment*
-

HOME SAFETY / HOME VISIT

*Consider home visit
(See RACGP Guidelines for checklist)*

- 23 Home Safety**
- Can you get down to and up from
your lounge chair easily and
safely? Y / N
- Can you get in and out of bed
easily and safely? Y / N
- Can you switch on a light easily
from your bed? Y / N
- Can you get on and off the toilet
easily and safely? Y / N
- Are all loose mats and floor
coverings securely fixed to the
floor? Y / N
- Do you use slip resistant mats or
self-adhesive non slip strips in the
bath/bathroom/shower recess? Y / N
- Can you carry meals easily and
safely from the kitchen to your
dining area? Y / N
- Are you able to grip and use
utensils efficiently and safely? Y / N
- Are the edges of the steps/stairs
easily identifiable? Y / N
- Actions suggested eg fitting of hand rails,
removal of hazards, improving access*
-
-
-
-
-

FUNCTIONAL ACTIVITIES

- 24 Mobility**
- Can you get around without a
mobility aid indoors? Y / N
 Outdoors? Y / N
- Can you bath/shower easily and
safely? Y / N
- Can you bend, kneel and stoop
easily and safely? Y / N
- Can you walk 100 metres easily? Y / N
- Can you go up and down access
steps to your home or internal
stairs easily and safely? Y / N
- Can you easily keep your balance
when you reach overhead? Y / N
- Are your walkways inside and
outside the house free of cords
and clutter? Y / N
- Is all the household lighting
adequate for you to see clearly? Y / N
- Have you been free of falls in the
home in the past 3 months? Y / N

Actions suggested

MEDICATION REVIEW

- 25 Complete the separate Medication Review Sheet**
Comment
-

RELEVANT PREVENTIVE CARE CHECKLIST

- 26 Vaccinations** date
- | | | |
|--------------|--------------------------|--|
| Influenza | <input type="checkbox"/> | |
| Pneumococcus | <input type="checkbox"/> | |
| Tetanus | <input type="checkbox"/> | |
| Other | <input type="checkbox"/> | |

Comments

- 27 Other areas for examination and or
follow up**
*eg Pap smears, weight bearing
exercise*
-
-
-
-