



Medicare Health Checks for Aboriginal and Torres Strait Islander Australians

Adult Health Check (15-54)

Use of a specific form to record the results of the health check is not mandatory but the health check should cover the matters listed below. The first page of this form can be used as a report of the health check.

Patient's Name Male Female DOB: ___/___/_____ or Age: _____
Aboriginal Torres Strait Islander Aboriginal and Torres Strait Islander
Work status.....

Current contact details

Address.....
Phone.....

Alternative contact details

Address.....
Phone.....

Patient Consent

Explanation of health check given Yes
Patient consent for health check given Yes
Date consent was given: ___/___/_____

Consent given for information to be collected by

Health worker
Practice Nurse
Other please specify

Previous health check

Has the patient had a previous health check?
No Yes

Date of last health check (if known) ___/___/_____
Service provided by DR

PATIENT'S OVERALL HEALTH

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.....
.....
.....

RISK FACTORS IDENTIFIED AND DISCUSSED WITH PATIENT

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.....
.....
.....

TESTS UNDERTAKEN, RESULTS AND WHAT THEY MEAN

(some results may not be available)

TEST	AVAILABLE RESULTS & WHAT THEY MEAN

**Medicare Health Checks for
Aboriginal and Torres Strait Islander Australians**



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STRATEGY FOR GOOD HEALTH: REQUIRED TREATMENT/SERVICES/HEALTH ADVICE

TREATMENT	HEALTH ADVICE	HEALTH SERVICES NEEDED

ACTION TO BE TAKEN BY PATIENT

.....

Next appointment with doctor:..... Date: ___/___/___ Next Health Assessment: ___/___/___

GP: Dr GP's Signature: Date: ___/___/___

MEDICAL HISTORY (MANDATORY)

FAMILY RELATIONSHIP

Does the patient care for someone else? No Yes

Is the patient cared for by someone else? No Yes

CURRENT PROBLEMS	CURRENT RISK FACTORS

ALLERGIES/DRUG INTOLERANCE

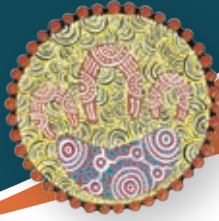
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CURRENT MEDICATIONS (including prescription and over the counter and supplied by doctor without prescription)

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RELEVANT FAMILY MEDICAL HISTORY

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IMMUNISATION STATUS (referring to current age/sex schedule)

TYPE	DATE	TYPE	DATE

PHYSICAL ACTIVITY

IDENTIFIED PROBLEMS	ACTION

NUTRITION

IDENTIFIED PROBLEMS	ACTION

ALCOHOL, TOBACCO AND OTHER SUBSTANCE USE

IDENTIFIED PROBLEMS	ACTION

HEARING LOSS

IDENTIFIED PROBLEMS	ACTION

MOOD (depression and self harm risk)

IDENTIFIED PROBLEMS	ACTION



SEXUAL AND REPRODUCTIVE HEALTH

IDENTIFIED PROBLEMS	ACTION

OTHER MEDICAL HISTORY AS INDICATED FOR PATIENT

VISUAL ACUITY (recommended for over 40s)

IDENTIFIED PROBLEMS	ACTION

ENVIRONMENTAL AND LIVING CONDITIONS

IDENTIFIED PROBLEMS	ACTION

Other history considered necessary by doctor or collector (eg work environment)

IDENTIFIED PROBLEMS	ACTION

MEDICAL EXAMINATION (MANDATORY)

BLOOD PRESSURE:..... PULSE RATE AND RHYTHM: Normal Abnormal

IDENTIFIED PROBLEMS	ACTION

WEIGHT: Height: BMI: Waist circumference (if indicated):

IDENTIFIED PROBLEMS	ACTION

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GUMS AND DENTITION: Normal Abnormal

IDENTIFIED PROBLEMS	ACTION

EAR AND HEARING: otoscopy Whisper test (if indicated)

IDENTIFIED PROBLEMS	ACTION

URINALYSIS

IDENTIFIED PROBLEMS	ACTION

OTHER MEDICAL EXAMINATION – optional as indicated for patient

TRICHIASIS

IDENTIFIED PROBLEMS	ACTION

SKIN

IDENTIFIED PROBLEMS	ACTION

REPRODUCTIVE AND SEXUAL HEALTH EXAMINATION

IDENTIFIED PROBLEMS	ACTION

VISUAL ACUITY (recommended for over 40 years old) Normal Abnormal

IDENTIFIED PROBLEMS	ACTION

OTHER EXAMINATIONS CONSIDERED NECESSARY BY GP

EXAMINATION	IDENTIFIED PROBLEMS	ACTION

INVESTIGATIONS AS REQUIRED

INVESTIGATION	TESTS DONE	TESTS ORDERED	ARRANGEMENTS (eg referral details)
Fasting blood sugar	<input type="checkbox"/>	Date: ___/___/_____	
Lipids	<input type="checkbox"/>	Date: ___/___/_____	
Pap Smear	<input type="checkbox"/>	Date: ___/___/_____	
STI	<input type="checkbox"/>	Date: ___/___/_____	
Mammography	<input type="checkbox"/>	Date: ___/___/_____	
Other:.....			

ASSESSMENT OF PATIENT (MANDATORY)

(based on consideration of evidence from patient history, examination and results of any investigation)

EXISTING HEALTH PROBLEMS	IDENTIFIED RISK FACTORS

INTERVENTION ACTION (MANDATORY)

HEALTH ADVICE PROVIDED TO PATIENT

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OTHER ACTION (if any)

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