

ANNUAL HEALTH ASSESSMENT

(For Patients aged 75 and over

Aboriginal and Torres Strait Islander 55 and over.)

Item Numbers: Al I Non ATSI Practice Home Aboriginal and Torres Strait Islander Practice Home
Item 700 Item 702 Item 704 Item 706
GP Name: _____ Signature: _____ Date: __/__/__

Patient Name _____ D.O.B _____ RN Name _____

Patient Consent: The Annual Health Assessment process has been explained and I agree to undertake it.

Signature: _____

1.General

Are you living: Alone As a couple With others
In general would you say your health is:
 Excellent Very Good Good Fair Poor

2. Genito / Urinary

Urine dipstick test albumen glucose blood

3.Immunisations

When did you last have immunisation for:
Tetanus.....Influenza.....Pneumococcus.....

4.Allergies

Do you have any allergies? Yes No
If so, what?
.....

5.Alcohol / Tobacco

Do you currently smoke? No Yes, number cigarettes per day?.....
Have you ever smoked? No Yes, for how long?
Do you drink Alcohol? No Yes, what type and quantity?
.....

6.Social Support

During the last 4 weeks was someone available if you needed or wanted help? For example if you:

*Felt very nervous, lonely or blue *Needed help with daily chores
*Got sick and had to stay in bed *Needed help just taking care of yourself
*Needed someone to talk to

Yes, as much as I needed Yes, quite a bit Yes, some Yes, a little No, not at all

Are you a carer for another person? No Yes

Do you currently receive any of the following Community Services?

Daycare Respite Care
 HACC – Home Help Community Nursing
 Meals on Wheels Podiatry
 Physiotherapy Other.....

7.Transport

Do you drive a car? Yes No

Details. _____

8.Mobility

Do you have difficulty with any of the following?

- Climbing one flight of stairs?
- Bending kneeling or stooping?
- Walking 100 meters?
- Bathing or dressing yourself?

None	A little	A lot

9.Hospital Attendance

Have you been in hospital in the past year?

No Yes

Have you attended at a hospital casualty / Emergency in the past year?

No Yes

If so, for what reason?

.....

10. Home Safety

- Can you get up from a lounge chair easily? Yes / No
- Can you get in and out of bed easily and safely? Yes / No
- Can you switch a light on easily from your bed? Yes / No
- Do you have loose mats on the floor? Are they securely fixed to the floor? Yes / No
- Do you use slip resistant mats in the shower / bath / bathroom? Yes / No
- Can you carry meals easily and safely from the kitchen to your dining area? Yes / No
- Do you have difficulty gripping utensils / handrails? Yes / No
- Are there steps at home / are the edges easily identified? Yes / No
- Have you had a fall of any type inside / outside in the past 3 months? Yes / No

If so, under what circumstances? Blackout Poor vision Loss of balance Accident

Other.....

11. In the past 12 months have you suffered with?

Pain in the calves when you walk	Yes / No	Shortness or breath	Yes / No
Chronic cough	Yes / No	Chest pain or tightening	Yes / No
Palpitations or “racing heart”	Yes / No	Diarrhoea / Constipation	Yes / No
Indigestion	Yes / No	Heart burn	Yes / No
Abdominal pain	Yes / No	Bloating	Yes / No
Broken skin that doesn’t heal	Yes / No	Coughing up of blood	Yes / No
Change in a wart or mole	Yes / No	Fainting / blackout / dizziness	Yes / No
Scaly areas on your skin	Yes / No	Severe headaches	Yes / No
Seizure or fit	Yes / No	Loss of vision	Yes / No
Blood from the back passage or black stools	Yes / No	Other symptoms you are worried about	Yes / No

12. Have you suffered any serious illness or had any operation in the past?

Year	Illness or Operation	Recovered or Ongoing

13. Feelings

In the past 4 weeks how much have you felt anxious, depressed, irritable, downhearted or blue?

- Not at all Slightly Moderately Quite a bit Extremely

14 Mood

Geriatric Depression Scale (GDS)

Ask the patient next to you to choose the best answer for how she/he has felt over the last week. Scoring: record the patients response by ticking either Yes or No for each question. Total the score.

	YES	NO
Are you basically satisfied with your life?	0	1
Have you dropped many of your interests and activities?	1	0
Do you feel that your life is empty?	1	0
Do you often get bored?	1	0
Are you in good spirits most of the time?	0	1
Are you afraid that something bad is going to happen to you?	1	0
Do you feel happy most of the time?	0	1
Do you often feel helpless?	1	0
Do you prefer to stay at home rather than going out and doing new things?	1	0
Do you feel you have more problems with your memory than most?	1	0
Do you think it is wonderful to be alive now?	0	1
Do you feel at all worthless the way you are now?	1	0
Do you feel you have enough energy?	0	1
Do you feel that your situation is hopeless?	1	0
Do you feel that most people are better off than you are?	1	0

(A score of greater than 5 indicates probable depression)

TOTAL SCORE _____

Comment.....

15. Continence

Female

- Do you pass urine when you cough or sneeze?
- Do you pass urine if you are unable to get to the toilet on time?
- Have you had vaginal bleeding or staining on your underwear?

No	Yes	Time in 24hrs

Male

- Do you have problems starting to pass urine?
- Do you have dribbling after passing urine?
- Do you pass urine accidentally?
- Have you passed blood in your urine?

How many times do you get up to pass urine at night?

times

Faecal Continence

- Do you pass bowel action accidentally? No Yes Times in 24hrs?.....
- Has your bowel habit changes in the past 12 months? No Yes Describe.....
-
-

Annual Health Assessment General Practitioner Examination

1. Current Medication Review Including supplements, herbal, homeopathic & over-the-counter medicine

Name	Strength	Dose	Frequency				Reason Taken
			Morn.	Lunch.	Dinner.	Night	

Does patient manage own medications? No Yes
 Does patient have difficulty remembering to take medications? No Yes
 Is a dosette box used? No Yes
 If so, who fills the dosette box?.....

Comment.....

2. Measurements

Height	Weight	BMI	Waist	Hip	WHR
m	kg		cm	cm	

3. Nutrition

- A. Has **food intake declined** over the past 3 months due to loss of appetite, **digestive problems, chewing or swallowing** difficulties?
- 0 = severe loss of appetite
 1 = moderate loss of appetite
 2 = no loss of appetite
- B. **Weight loss** during last months
- 0 = weight loss greater than 3kgs. (6.6lbs)
 1 = does not know
 2 =weight loss between 1 and 3 kg. (2.2 and 6.6lbs)
 3 =no weight loss
- C. **Mobility**
- 0 = bed or chair bound
 1 = able to get out of bed / chair but does not go out
 2 = goes out
- D. Has suffered **psychological stress or acute disease** in the past 3 months
- 0 = yes
 2 = no

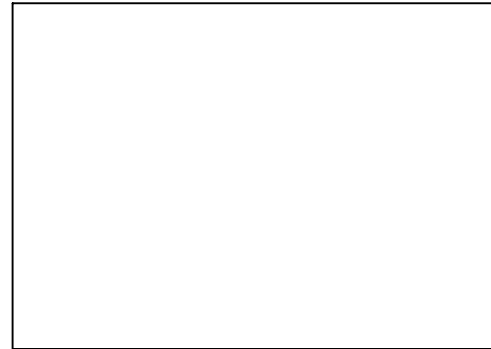
Take score on to next page

6. Abdomen

Scars No / Yes
 Distention No / Yes
 Liver enlarged No / Yes
 Spleen enlarged No / Yes
 Mass No / Yes
 Rectal Exam Not done / done

Comments.....
 Herniae No / Yes

Comments.....



7. Joint Movement

		Normal		Abnormal				Comments
		Yes	No	Pain	Swelling	ROM	Deformity	
Shoulder	R							
	L							
Hips	R							
	L							
Knees	R							
	L							
Ankles & Foot	R							
	L							
Neck								
Thoracic spine								
Lumbar spine								
Gait					Comments			

8. Respiratory

Air entry Normal / Reduced Symmetrical Yes / No
 Dyspnoea at rest? Yes / No
 Breath sounds Normal / Abnormal Describe.....

9. Skin

Obvious lesions

Need for full skin check at another appointment? Yes / No

10. Breasts

Normal Suspicious
 Lump (area/s) Skin changes.....

11. Gynecology (if applicable)

PV Not done / Done Comments.....

GENERAL SUMMARY of Annual Health Assessment

Date _____/_____/_____

Name _____ D.O.B _____

Cardiovascular Status: BP _____ Pulse _____ Rhythm _____

Physical Condition: good / fair / poor / very bad

Mental State: alert / mildly impaired / mod. Impaired / severely impaired

Ambulant Status: ambulant / walks with assistance / chair bound / bedfast

Activities of daily living: independent / little assistance / mod. dependence / totally dependent

Falls: in past 3 months Yes / No

Support:

- Lives with supportive spouse / family
- Lives alone with support / special accommodation house
- Lives with unsupportive spouse / family / hostel
- Lives alone without support

Mini mental score: / 29

Nutrition score / status:

Mood / depression score / status:

Immunisation Status:

Tet. Toxoid or ADT	Yes / No
Influenza Vaccine	Yes / No
Pneumococcal Vaccine	Yes / No

Contenance: Yes / No Comments:

Medication Review:

Recommendations:

- I found no problems with your health
- I recommend that you make another appointment to discuss or investigate the following findings.

Alterations / recommendations:

Signed:

GP Name / Practice Stamp:

Patient Acknowledgement

I have read and understood my doctor's recommendations regarding my Annual Health Assessment.

I would like a reminder for my health Assessment in 12 months.

Signed: Patient / Carer _____

***A copy of this summary sheet has been offered to patient** Yes