



Medicare Health Checks for Aboriginal and Torres Strait Islander People

Adult Health Check (15-54)

MBS item 710

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 in the Explanatory Notes for the health check in the Medicare Benefits Schedule book. 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

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

RISK FACTORS IDENTIFIED AND DISCUSSED WITH PATIENT

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

TESTS UNDERTAKEN, RESULTS AND WHAT THEY MEAN

(some results may not be available)

| TEST | AVAILABLE RESULTS & WHAT THEY MEAN |
|------|------------------------------------|
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| | |
| | |
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**Medicare Health Checks for
Aboriginal and Torres Strait Islander People**



Adult Health Check (15-54)

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 ISSUES | CURRENT RISK FACTORS |
|----------------|----------------------|
| | |
| | |
| | |

ALLERGIES/DRUG INTOLERANCE

.....

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

.....

RELEVANT FAMILY MEDICAL HISTORY

.....



IMMUNISATION STATUS (referring to current age/sex schedule)

| TYPE | DATE | TYPE | DATE |
|------|------|------|------|
| | | | |
| | | | |
| | | | |

PHYSICAL ACTIVITY

| IDENTIFIED ISSUES | ACTION |
|-------------------|--------|
| | |
| | |
| | |

NUTRITION

| IDENTIFIED ISSUES | ACTION |
|-------------------|--------|
| | |
| | |
| | |

ALCOHOL, TOBACCO AND OTHER SUBSTANCE USE

| IDENTIFIED ISSUES | ACTION |
|-------------------|--------|
| | |
| | |
| | |

HEARING LOSS

| IDENTIFIED ISSUES | ACTION |
|-------------------|--------|
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| | |
| | |

MOOD (depression and self harm risk)

| IDENTIFIED ISSUES | ACTION |
|-------------------|--------|
| | |
| | |
| | |



SEXUAL AND REPRODUCTIVE HEALTH

| IDENTIFIED ISSUES | ACTION |
|-------------------|--------|
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OTHER MEDICAL HISTORY AS INDICATED FOR PATIENT

VISUAL ACUITY (recommended for over 40s)

| IDENTIFIED ISSUES | ACTION |
|-------------------|--------|
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| | |

ENVIRONMENTAL AND LIVING CONDITIONS

| IDENTIFIED ISSUES | ACTION |
|-------------------|--------|
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| | |
| | |

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

| IDENTIFIED ISSUES | ACTION |
|-------------------|--------|
| | |
| | |
| | |

MEDICAL EXAMINATION (MANDATORY)

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

| IDENTIFIED ISSUES | ACTION |
|-------------------|--------|
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| | |
| | |

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

| IDENTIFIED ISSUES | ACTION |
|-------------------|--------|
| | |
| | |
| | |

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GUMS AND DENTITION: Normal Abnormal

| IDENTIFIED ISSUES | ACTION |
|-------------------|--------|
| | |
| | |
| | |

EAR AND HEARING: Otoscopy Whisper test (if indicated)

| IDENTIFIED ISSUES | ACTION |
|-------------------|--------|
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| | |

URINALYSIS

| IDENTIFIED ISSUES | ACTION |
|-------------------|--------|
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| | |
| | |

OTHER MEDICAL EXAMINATION – AS INDICATED FOR PATIENT

TRICHIASIS

| IDENTIFIED ISSUES | ACTION |
|-------------------|--------|
| | |
| | |
| | |

SKIN

| IDENTIFIED ISSUES | ACTION |
|-------------------|--------|
| | |
| | |
| | |

OTHER EXAMINATIONS CONSIDERED NECESSARY BY GP

| EXAMINATION | IDENTIFIED ISSUES | 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 ISSUES | IDENTIFIED RISK FACTORS |
|------------------------|-------------------------|
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| | |

INTERVENTION ACTION (MANDATORY)

HEALTH ADVICE PROVIDED TO PATIENT

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.....
.....

OTHER ACTION (if any)

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