Health and chronic conditions

Purpose:to assist service providers to screen for health and chronic conditions

Consumer

Name:

Date of Birth: dd/mm/yyyy / /

Sex:

UR Number:

or affix label here

General health and health literacy

Health literacy Do you have difficulty understanding information, instructions or written material you receive from your doctor or other health professionals?	Code: ☐
General health In general, you would say your health is:	Code: ☐
Self-care What do you do to take care of yourself and your health?	
Main concerns What do you see as your main health and wellbeing concerns or issues?	
Making changes Have you thought about making changes to improve your health and wellbeing?	☐ Yes ☐ No ☐ Not stated/unknown
GP check-ups Have you had check-ups with your GP in the last 12 months?	☐ Yes ☐ No ☐ Not stated/unknown ☐ Don't have a GP
Eye checks When did you last have your eyes checked?	
Hearing How is your hearing (with your hearing aid)?	Code: ☐

Health and chronic conditions

Have you ever been told by a doctor or nurse that you have the following conditions?

☐	**Breathing** problems (Respiratory condition For example asthma, shortness of breath)	☐	**Diabetes**
☐	**Cancer** If yes, state type:	☐	**High blood pressure** (hypertension)
☐	**Heart** problems (cardiovascular or heart disease)	☐	**Arthritis, osteoporosis** (musculoskeletal conditions)
☐	Chronic **kidney** disease	☐	**Stroke, Parkinson's disease,** **multiple sclerosis** or other neurological disorders
Other and/or comments:			

Produced by the Victorian Department of Health, 2012

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Falls risk

Have you had any falls in or around your home in the past 12 months?	☐ Yes ☐ No ☐ Not stated/unknown

Pain

How much bodily pain have you had during the past 4 weeks?	Code: ☐

Physical activity

In the past week, on how many days have you done a total of 30 minutes or more of physical activity, which was enough to raise your breathing rate?	

Nutritional risk

☐ Obvious underweight – frailty?	☐ Frequent chest infections?
☐ **Unintentional** weight loss?	☐ Follows a special diet?
☐ Obvious overweight affecting life quality?	☐ Needs assistance to shop for food, prepare food or to feed themselves?
☐ Unintentional weight gain?	☐ Has the consumer had any recent changes in circumstances that have affected what they eat, how they prepare meals or how they shop?
☐ Reduced appetite or reduced food and fluid intake?	☐ Are there concerns about the client's ability to have an adequate diet?
☐ Mouth or teeth problem?	☐ No risk identified
☐ Chewing or swallowing problem? (eg choking or coughing during/after meals)?	

Social isolation

How often do you feel isolated from others?	Code: ☐

Advance Care Planning

Does the consumer have an Advance Care Plan? Does this include a not for treatment order?	☐ Yes ☐ No ☐ Not stated/unknown If yes, where is it kept? ☐ Yes ☐ No ☐ Not stated/unknown
Does the consumer have a nominated substitute decision maker (enduring power of attorney medical treatment) in relation to medical decisions?	☐ Yes ☐ No ☐ Not stated/unknown If yes, name of substitute decision maker?

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