# Health and chronic conditions

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

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**Consumer**

Name: 
Date of Birth: dd/mm/yyyy  
Sex: 
UR Number: or affix label here

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## 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:

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Position/Agency:  
Sign:  
Date: dd/mm/yyyy  
Contact number:
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### Falls risk

<table>
<thead>
<tr>
<th>Have you had any falls in or around your home in the past 12 months?</th>
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<tbody>
<tr>
<td></td>
<td>Yes</td>
<td>No</td>
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</table>

### Pain

<table>
<thead>
<tr>
<th>How much bodily pain have you had during the past 4 weeks?</th>
<th>Code:</th>
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</table>

### Physical activity

<table>
<thead>
<tr>
<th>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?</th>
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</thead>
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### Nutritional risk

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- **Obvious underweight – frailty?**
- **Unintentional** weight loss?
- **Obvious overweight affecting life quality?**
- **Unintentional weight gain?**
- **Reduced appetite or reduced food and fluid intake?**
- **Mouth or teeth problem?**
- **Chewing or swallowing problem? (eg choking or coughing during/after meals)?**

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- **Frequent chest infections?**
- **Follows a special diet?**
- **Needs assistance to shop for food, prepare food or to feed themselves?**
- **Has the consumer had any recent changes in circumstances that have affected what they eat, how they prepare meals or how they shop?**
- **Are there concerns about the client’s ability to have an adequate diet?**

### Social isolation

<table>
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<tr>
<th>How often do you feel isolated from others?</th>
<th>Code:</th>
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### Advance Care Planning

<table>
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<th>Does the consumer have an Advance Care Plan?</th>
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<tbody>
<tr>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Does this include a not for treatment order?</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Does the consumer have a nominated substitute decision maker (enduring power of attorney medical treatment) in relation to medical decisions?</td>
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<tr>
<td></td>
<td>Yes</td>
<td>No</td>
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