

**Health Assessment 45-49 years**

Date: \_\_\_/\_\_\_/\_\_\_\_\_

Family name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Given name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: Home: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mobile: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB: \_\_\_/\_\_\_/\_\_\_\_\_ Age: \_\_\_\_\_ Number of children: \_\_\_\_ Marital Status: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family History**

**Current situation**:

**Father**: [ ] Living Current age: \_\_\_

 [ ] Not living Age of death: \_\_\_ Cause: \_\_\_\_\_\_\_\_\_\_\_\_ Duration of illness: \_\_\_\_\_\_\_\_\_\_\_\_\_

Any health problems? [ ] Diabetes [ ] Kidney disease [ ] Asthma [ ] High blood pressure

(If no, skip this question) [ ] Breast cancer [ ] Colon cancer [ ] Stroke [ ] Depression [ ] Epilepsy [ ] Other cancer [ ] Heart disease [ ] Others: please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Mother:** [ ] Living Current age: \_\_\_

 [ ] Not living Age of death: \_\_\_ Cause: \_\_\_\_\_\_\_\_\_\_\_\_ Duration of illness: \_\_\_\_\_\_\_\_\_\_\_\_\_

Any health problems? [ ] Diabetes [ ] Kidney disease [ ] Asthma [ ] High blood pressure

(If no, skip this question) [ ] Breast cancer [ ] Colon cancer [ ] Stroke [ ] Depression [ ] Epilepsy [ ] Other cancer (specify)[ ] Heart disease [ ] Others: please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Siblings:** [ ] Living Current age: \_\_\_

 [ ] Not living Age of death: \_\_\_ Cause: \_\_\_\_\_\_\_\_\_\_\_\_ Duration of illness: \_\_\_\_\_\_\_\_\_\_\_\_\_

Any health problems? [ ] Diabetes [ ] Kidney disease [ ] Asthma [ ] High blood pressure

(If no, skip this question) [ ] Breast cancer [ ] Colon cancer [ ] Stroke [ ] Depression [ ] Epilepsy [ ] Other cancer (specify)[ ] Heart disease [ ] Others: please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Siblings:** [ ] Living Current age: \_\_\_

 [ ] Not living Age of death: \_\_\_ Cause: \_\_\_\_\_\_\_\_\_\_\_\_ Duration of illness: \_\_\_\_\_\_\_\_\_\_\_\_\_

Any health problems? [ ] Diabetes [ ] Kidney disease [ ] Asthma [ ] High blood pressure

(If no, skip this question) [ ] Breast cancer [ ] Colon cancer [ ] Stroke [ ] Depression [ ] Epilepsy [ ] Other cancer (specify)[ ] Heart disease [ ] Others: please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Siblings:** [ ] Living Current age: \_\_\_

 [ ] Not living Age of death: \_\_\_ Cause: \_\_\_\_\_\_\_\_\_\_\_\_ Duration of illness: \_\_\_\_\_\_\_\_\_\_\_\_\_

Any health problems? [ ] Diabetes [ ] Kidney disease [ ] Asthma [ ] High blood pressure

(If no, skip this question) [ ] Breast cancer [ ] Colon cancer [ ] Stroke [ ] Depression [ ] Epilepsy [ ] Other cancer (specify)[ ] Heart disease [ ] Others: please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical History**

Present medical complaints: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any prescribed medications you are currently taking: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any over the counter medications (multivitamins, herbal pills, supplements) you are taking:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any major illnesses in the past:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any hospitalisations or operations:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you have had any of the following complaints, please tick the appropriate box:

|  |  |
| --- | --- |
| Heart attackHeart complaintsChest painHigh blood pressurePalpitationsRheumatic fever | Defect in sightDefect in hearingDefect in speech |
| AsthmaTuberculosisPneumonia/ PleurisyChronic bronchitisCoughing up bloodOther lung complaints | Allergies to drugsOther allergies/hay fever etcLiver problems/hepatitis/jaundiceGlandular fever |
| Stomach or duodenal ulcerChronic indigestionIntestinal or bowel troublesChronic constipationHaemorrhoidsVomiting bloodPassing blood in motionsNephritisKidney infections/stoneBladder disorders / cystitisTrouble passing urine, prostate troublePassing blood in urinePassing urine more than once per night | Diabetes AnaemiaBleeding disordersOther blood disordersBlood transfusionsVascular / blood vessel problems |
| Changes in size, colour in mole/freckleCancer, cysts, tumoursRecent skin soresSkin problems | ArthritisBone or joint problemsBack complaintsNeck complaintsGoutMuscular illnessHernias/ruptures |
| AIDS or AIDS related condition | Epilepsy or fitsBlackouts/fainting attacksHead injuriesChronic headachesMigraine |

**Medical history – Female patients**

Number of children: \_\_\_\_\_ Ages: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any painful discharge/itch? [ ] Yes [ ] No

Premenstrual tension? [ ] Yes [ ] No

Are you taking the pill or other hormones? [ ] Yes [ ] No

If yes, any side effects? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any history of ovarian/uterine problems eg cysts? [ ] Yes [ ] No

Any breast swelling/cysts/lumps/nipple discharge? [ ] Yes [ ] No

Do you regularly examine your breasts? [ ] Yes [ ] No

Date of last Pap smear test: \_\_\_\_\_\_\_\_\_\_\_\_\_ Date of last mammography: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any other health complaints, eg heavy bleeding / irregularity?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical history – Male patients**

Date of last prostate check: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Physical examination**

Height: \_­\_\_\_­cm Weight: \_\_\_\_\_kg BP: Systolic: \_\_\_\_\_\_ Diastolic: \_\_\_\_\_\_

Urine: Protein [ ] Yes [ ] No

Urine: Blood [ ] Yes [ ] No

Urine: Sugar [ ] Yes [ ] No

**Skin:**

Eczema/dermatitis: [ ] Yes [ ] No

Scars: [ ] Yes [ ] No

Sun damage: [ ] Yes [ ] No

Other abnormalities: [ ] Yes [ ] No

**Vision:**

Colour vision normal: [ ] Yes [ ] No

Wears glasses: [ ] Yes [ ] No

Visual acuity w/ lens: **R:** 6/\_\_\_ **L:** 6/\_\_\_

**Hearing:**

Hearing test normal: [ ] Yes [ ] No

Ear examination: TM \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Spirometry:**

|  |  |  |  |
| --- | --- | --- | --- |
|  | FEV1 | FVC | % |
| Observed |  |  |  |
| Predicted |  |  |  |
| Spirometry normal: [ ] Yes [ ] No |
| Peak flow: | Litres: |

**Social history**

Smoking:

Do you smoke? [ ] Yes [ ] No If no, have you ever smoked? [ ] Yes [ ] No

If yes to either, daily average: \_\_\_\_\_\_\_\_\_\_\_\_\_ From age \_\_\_\_\_\_\_to \_\_\_\_\_\_\_\_

Alcohol:

Do you drink alcohol? If yes, do you drink beer? Average quantity per week: \_\_\_\_\_\_\_\_\_\_\_\_

If yes, do you drink wine? Average quantity per week: \_\_\_\_\_\_\_\_\_\_\_\_

If yes, do you drink spirit? Average quantity per week: \_\_\_\_\_\_\_\_\_\_\_\_

Have you ever felt you should cut down on your drinking? [ ] Yes [ ] No

Have you ever felt bad or guilty about your drinking? [ ] Yes [ ] No

Have you ever felt annoyed when people criticised your drinking? [ ] Yes [ ] No

Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover? [ ] Yes [ ] No

Weight:

Any weight gain in the last 2 years? [ ] Yes [ ] No If yes, how much? \_\_\_\_\_\_\_kg

Any recent intentional/unintentional weight? [ ] Yes [ ] No If yes, how much? \_\_\_\_\_\_\_kg

Approx weight at age: 20: \_\_\_\_\_kg 30:­\_\_\_\_\_kg 40: \_\_\_\_\_kg 50: \_\_\_\_\_\_kg

**Physical activity:**

How do you rate the amount of physical activity you perform while at work?

[ ]  Very little [ ]  Little [ ] Moderate [ ] Active [ ]  Very active

How would you rate the amount of physical activity you perform during your leisure time?

[ ]  Very little [ ]  Little [ ] Moderate [ ] Active [ ]  Very active

How physically fit do you feel at the moment?

[ ]  Unfit [ ]  Below average [ ] Average [ ] Above average [ ]  Very fit

Please list physical activities you take part in:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | How many times per week | Average duration in minutes | Exertion levelEasy, moderate, hard | Active for how many months | V =Very regularO =Occasionally missI =Irregular |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

**Doctor’s use only**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Insp cm | Exp cm | Lungs | Clear |
| Abdomen | No masses | Girth: cm | Heart sounds | 2HS NB |
| Hernia |  | Apex beat | Not palpable |
| Pulse | Normal volume & regular | Carotids | No bruits |
| PR Exam | Grade I / II / III | Smooth / nodular | Soft / firm | Bilobed:[ ] Yes [ ] No |
| Lymph nodes |  | Thyroid |  |
| Low back/spine |  | Nervous system |  |
| Acuity | R  | L | Nervous system |  |
| Ears | EAM | TM  |  |  |
| Peripheral reflexes | BJ | KJ | AJ | Peripheral joints: |
| Breast examination |  | Genitalia |  |

|  |
| --- |
| Nurses commentsSigned: Date: |

|  |
| --- |
| Doctors commentsSigned: Date: |