

**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: \_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

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**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 attack  Heart complaints  Chest pain  High blood pressure  Palpitations  Rheumatic fever | Defect in sight  Defect in hearing  Defect in speech |
| Asthma  Tuberculosis  Pneumonia/ Pleurisy  Chronic bronchitis  Coughing up blood  Other lung complaints | Allergies to drugs  Other allergies/hay fever etc  Liver problems/hepatitis/jaundice  Glandular fever |
| Stomach or duodenal ulcer  Chronic indigestion  Intestinal or bowel troubles  Chronic constipation  Haemorrhoids  Vomiting blood  Passing blood in motions  Nephritis  Kidney infections/stone  Bladder disorders / cystitis  Trouble passing urine, prostate trouble  Passing blood in urine  Passing urine more than once per night | Diabetes  Anaemia  Bleeding disorders  Other blood disorders  Blood transfusions  Vascular / blood vessel problems |
| Changes in size, colour in mole/freckle  Cancer, cysts, tumours  Recent skin sores  Skin problems | Arthritis  Bone or joint problems  Back complaints  Neck complaints  Gout  Muscular illness  Hernias/ruptures |
| AIDS or AIDS related condition | Epilepsy or fits  Blackouts/fainting attacks  Head injuries  Chronic headaches  Migraine |

**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 level  Easy, moderate, hard | Active for how many months | V =Very regular  O =Occasionally miss  I =Irregular |
|  |  |  |  |  |  |
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**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 comments  Signed: Date: |

|  |
| --- |
| Doctors comments  Signed: Date: |