

# Profile: Health Conditions

To assist workers/practitioners to screen for consumer's health needs.

## Consumer

Name: \_\_\_\_\_

Date of Birth: dd/mm/yyyy / /

Sex: \_\_\_\_\_

UR Number: \_\_\_\_\_

or affix label here

## Overall Health

**Q1** In general, how would you say your health is?

\_\_\_\_\_ Code:

**Q2** How much did your health interfere with your normal activities (outside and/or inside the home) during the past 4 weeks? \_\_\_\_\_

Code:

## Pain

How much bodily pain have you had during the past 4 weeks? \_\_\_\_\_

Code:

## Hearing

How is your hearing (with your hearing aid)? \_\_\_\_\_

Code:

## Vision

**Q1** How is your eyesight for reading (with your glasses)? \_\_\_\_\_

Code:

**Q2** How is your long distance eyesight (with your glasses)? \_\_\_\_\_

Code:

## Falls

**Q1** Do you have a fear of falling? \_\_\_\_\_

Code:

**Q2** Have you had a fall inside/outside the home in the past 6 months? \_\_\_\_\_

Code:

Consider both activities of daily living and need for referral if the consumer has any problems with any of the above.

## Health Conditions

(include all issues eg, allergies, acute medical conditions, disabilities, continence, dental, developmental problems)

- |          |           |
|----------|-----------|
| 1. _____ | 6. _____  |
| 2. _____ | 7. _____  |
| 3. _____ | 8. _____  |
| 4. _____ | 9. _____  |
| 5. _____ | 10. _____ |

## Current Medications

(include prescriptions, over-the-counter and alternate products)

- |          |           |
|----------|-----------|
| 1. _____ | 6. _____  |
| 2. _____ | 7. _____  |
| 3. _____ | 8. _____  |
| 4. _____ | 9. _____  |
| 5. _____ | 10. _____ |

Note: Polypharmacy may suggest a medication review is desirable

Comments:

Referral Recommended To:

Health Conditions