

# 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:

## Chronic Conditions

Do you have a diagnosed chronic condition? \_\_\_\_\_

Code:

If yes, list conditions under Health Conditions and consider completing the Health Behaviors profile to identify modifiable risk factors and/or consider referral to chronic disease management and/or lifestyle intervention program.

## Oral Health

Are you currently experiencing any problems with your gums, mouth or teeth?  
(Example: broken teeth, fillings, bleeding or swollen gums, dentures that fit poorly or cause discomfort).

Yes  No. If yes, please list under health conditions and consider referral to a dental clinician if the consumer has problems with their oral health and/or has not had a check-up in 3 years.

## Vision

**Q1** Do you have difficulty with vision, even with glasses?

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

**Q2** Do you have difficulties carrying out your daily activities due to poor vision?

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

## Hearing

How is your hearing (with your hearing aid)?

\_\_\_\_\_ 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:

Health Conditions

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 and/or chronic medical conditions, disabilities, depression, continence, dental, developmental problems)

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

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## 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:

Health Conditions

Referral Recommended To: