Queensland Government
Queensland Health

Metro South Health Service District

Indigenous Health Check: Age 5-14

Community Health

UR Number	
Surname	
Other Names	
DOB	
Sex	

An * indicates a mandatory field.

A. PATIENT DETAILS

Age: *	
Is there consent by parent/carer to perform health check? *	◯ Yes ◯ No

Consent for health assessment to be used in research *	◯ Yes ◯ No		
Had a previous 715 (5-14) at this practice?	◯ Yes ◯ No ◉ Missing	Is there any new medical and family history?	◯ Yes ◯ No ◉ Missing
Mother's Name:		Mother's Age:	Mother's URN: ◯ Not in ERIC
Father's Name:		Father's Age:	Father's URN: ◯ Not in ERIC
OR			
Carer's Name (and relationship to child):			

Sibling Name		Sibling Age:	

Add Siblings

Single Parent:	◯ Yes ◯ No ◉ Missing
Mother Employed:	◯ Yes ◯ No ◯ Unsure ◉ Missing
Father Employed:	◯ Yes ◯ No ◯ Unsure ◉ Missing
Other people involved in the child's care:	

Indigenous Status

Child: *	◯ Aboriginal ◯ Torres Strait ◯ Both ◉ Missing
Mother: *	◯ Aboriginal ◯ Torres Strait ◯ Both ◯ Non-Indigenous ◉ Missing

Father: *	◯ Aboriginal ◯ Torres Strait ◯ Both ◯ Non-Indigenous ◉ Missing

B. PREVIOUS HEALTH CHECKS

Has the patient had a previous Medicare item 715 (5-14) Health Check?	◯ Yes ◯ No ◯ Unsure ◉ Missing
Has the patient had a paediatric review in the last 12 months	◯ Yes ◯ No ◯ Unsure ◉ Missing

C. IMMUNISATION STATUS

Is the patient's immunisation status up to date?	◯ Yes ◯ No ◯ Unsure ◉ Missing
Comments:	

D. MEDICAL HISTORY

Birth

What was the mode of delivery?	◯ Vaginal ◯ Caesarean ◯ Unsure ◉ Missing
What was the gestation (weeks) at birth? *	k
What was the birth weight (grams)? *	**g**
Were there any complications during or shortly after delivery?	◯ Yes ◯ No ◉ Missing
If yes please specify:	
Were there any other antenatal/ postnatal issues of concern?	◯ Yes ◯ No ◉ Missing
If yes please specify:	
Did the child receive neonatal screening for hearing?	◯ Yes ◯ No ◯ Unsure ◉ Missing
What was the outcome?	◯ Pass ◯ Fail ◉ Missing
Regular Snoring	◯ Yes ◯ No ◯ Unsure ◉ Missing
Number of URTIs in the past year?	
Any constipation in the past year?	◯ Yes ◯ No ◉ Missing

Past Medical History

Growth faltering/Failure to Thrive:	◯ Yes ◯ No ◯ Unsure ◉ Missing

Recurrent chest infection:	○ Yes ○ No ○ Unsure ◉ Missing
Pneumonia:	○ Yes ○ No ○ Unsure ◉ Missing
Rheumatic Heart Disease:	○ Yes ○ No ○ Unsure ◉ Missing
Asthma:	○ Yes ○ No ○ Unsure ◉ Missing
Ear infections:	○ Yes ○ No ○ Unsure ◉ Missing
Skin infections:	○ Yes ○ No ○ Unsure ◉ Missing
Other:	○ Yes ○ No ○ Unsure ◉ Missing
If Other, please specify - hospitalisations, injuries, burns:	
Relevant Family Medical History (Mother or Father):	
Hypertension:	○ Yes ○ No ○ Unsure ◉ Missing
Gestational Diabetes:	○ Yes ○ No ○ Unsure ◉ Missing
CVD:	○ Yes ○ No ○ Unsure ◉ Missing
Mental illness (e.g. depression, anxiety, schizophrenia):	○ Yes ○ No ○ Unsure ◉ Missing
Asthma/Atopy/Eczema:	○ Yes ○ No ○ Unsure ◉ Missing
Other:	○ Yes ○ No ○ Unsure ◉ Missing
Please specify - if yes to any of the above:	
CHILD	
Current Medications (prescriptions and over the counter):	
Allergies/drug intolerances:	

E. SOCIAL HISTORY/CARER CONCERNS

Who does the child live with? (e.g parent, grandparent, friend?)	Parent	○ Yes ○ No ◉ Missing
	Siblings	○ Yes ○ No ◉ Missing
	Grandparent	○ Yes ○ No ◉ Missing
	Foster Parent	○ Yes ○ No ◉ Missing

	Friend	◯ Yes ◯ No ◉ Missing
	Other	◯ Yes ◯ No ◉ Missing
If Other, please specify:		
Who is the primary carer of the child?		
How many people usually live at the house?		
Does the carer have any concerns about the child's development?	◯ Yes ◯ No ◉ Missing	
Any concerns about hearing?	◯ Yes ◯ No ◉ Missing	
Any concerns about talking?	◯ Yes ◯ No ◉ Missing	
Any concerns about vision?	◯ Yes ◯ No ◉ Missing	
If Yes to any of the above, please specify:		

Stressful Life Events

Have there been any stressful life events to cause you or your child to be upset?	◯ Yes ◯ No ◉ Missing
Conflict at home?	◯ Yes ◯ No ◉ Missing
Family Deaths?	◯ Yes ◯ No ◉ Missing
Exposure to violence?	◯ Yes ◯ No ◉ Missing
Illness to primary caregiver?	◯ Yes ◯ No ◉ Missing
Abuse?	◯ Yes ◯ No ◉ Missing
Comments:	
Are there any concerns about the mother/carer's current well-being?	◯ Yes ◯ No ◉ Missing
If Yes, please specify (e.g. support network, stressors, mood, general health)	

Domestic Violence/Abuse

Are you ever afraid of your partner?	◯ Yes ◯ No ◉ Missing
In the last year, has your partner kicked, punched or otherwise hurt you?	◯ Yes ◯ No ◉ Missing
In the last year, has you partner threatened to hurt you?	◯ Yes ◯ No ◉ Missing
Do you feel threatened or afraid of anyone in the	◯ Yes ◯ No ◉ Missing

community?	
Would you like help with any of this now?	○ Yes ○ No ◉ Missing
Has the parent experienced abuse as a child? (emotional, neglect, physical, sexual):	○ Yes ○ No ◉ Missing
If yes, please comment as appropriate:	

F. LEARNING AND BEHAVIOUR

Does the child attend school?	○ Yes ○ No ○ Unsure ◉ Missing
If Yes, what year?	
Does the parent/carer have any concerns about learning?	○ Yes ○ No ◉ Missing
If Yes, please specify:	
Does the parent/carer have any concerns about behaviour?	○ Yes ○ No ◉ Missing
If Yes, please specify:	
Does the teacher have any concerns about learning or behaviour?	○ Yes ○ No ◉ Missing
If Yes, please specify:	
What marks does your child receive on their report card?	○ Above average ○ Average ○ Below average ○ Unsure ◉ Missing
Has the child been suspended / expelled from school	○ Yes ○ No ◉ Missing
Comments	
Has the child moved schools in the past 12 months	○ Yes ○ No ◉ Missing
If yes, how many times?	

G. NUTRITION

Was the child ever breastfed?	○ Yes ○ No ◉ Missing
If Yes, what age was the breastfeeding stopped?	months
Was the child ever bottle fed?	○ Yes ○ No ◉ Missing

Is the child currently bottle fed?	◯ Yes ◯ No ◉ Missing
If No, what age was the bottle feeding stopped?	months
What age did the child start solids?	months
What was their first solid food?	
What is the child's typical diet?	
Breakfast:	
Lunch:	
Dinner:	
Snacks:	
What is the vegetable and fruit component of this diet?	◯ None ◯ Less than 5 serves of vegetables and 2 serves of fruit ◯ Equal to or more than 5 serves of vegetables and 2 serves of fruit ◉ Missing
How many times in the past week has the child had take away food?	
Since this time yesterday has the baby/child had any of the following?	
Flavoured milk:	◯ Yes ◯ No ◉ Missing
Tea:	◯ Yes ◯ No ◉ Missing
Soft drink/cordial:	◯ Yes ◯ No ◉ Missing
Fruit juice:	◯ Yes ◯ No ◉ Missing
Water:	◯ Yes ◯ No ◉ Missing
Any concerns about diet?	◯ Yes ◯ No ◉ Missing
If Yes, please specify:	
Activity	
Did the child exercise / play sport?	◯ Yes ◯ No ◉ Missing
How often in a week is the child physically active?	
A session is > 30 mins exercise that raised their heart rate or caused them to huff and puff.	
How much time (minutes) did the child spend on screen-based media for fun in the previous day (or most recent school day)?	
Screen based media includes watching DVDs, playing video or computer games, internet chatrooms.	
Any other	

comments/observations related to nutrition/physical activity?:	

G. PARENTAL SUBSTANCE USE

Smoking

Does anyone living in the household currently smoke regularly?	◯ Yes ◯ No ◉ Missing
If Yes, does anyone smoke inside the house?	◯ Yes ◯ No ◉ Missing
If Yes, please state the relationship to the child: Mother, Father, Other (please specify)	
If Yes, do they want assistance to quit smoking?	◯ Yes ◯ No ◯ Unsure ◉ Missing

Alcohol *Based on current national alcohol guidelines

Does the child's mother drink alcohol?	◯ Yes ◯ No ◉ Missing
If Yes, please state if harmful or non-harmful levels:	☐ > 2 std drinks/day avg; drinks 6-7 days/wk; > 14 std drinks/wk ☐ ⩽ 2 std drinks/day, 1-2 alcohol free days/wk; <14 std drinks/wk ☐ > 4 std drinks on any one day ☑ Missing
Does the child's father drink alcohol?	◯ Yes ◯ No ◉ Missing
If Yes, please state if harmful or non-harmful levels:	☐ > 4 std drinks/day avg or drinks 6-7 days/wk or > 28 std drinks/wk ☐ ⩽ 4 std drinks/day, 1-2 alcohol free days/wk or < 28 std drinks/wk ☐ > 6 std drinks on any one day ☑ Missing

Other Substances

Does a parent/carer use other substances?	◯ Yes ◯ No ◉ Missing	
Marijuana	◯ Yes ◯ No ◉ Missing	◯ Daily ◯ Weekly ◯ Monthly ◯ Occasionally ◉ Missing
Amphetamines/Ice	◯ Yes ◯ No ◉ Missing	◯ Daily ◯ Weekly ◯ Monthly ◯ Occasionally ◉ Missing
Heroin	◯ Yes ◯ No ◉ Missing	◯ Daily ◯ Weekly ◯ Monthly ◯ Occasionally ◉ Missing
Cocaine	◯ Yes ◯ No ◉ Missing	◯ Daily ◯ Weekly ◯ Monthly ◯ Occasionally ◉ Missing
Inhaled solvents	◯ Yes ◯ No ◉ Missing	◯ Daily ◯ Weekly ◯ Monthly ◯ Occasionally ◉ Missing
Methadone	◯ Yes ◯ No ◉ Missing	◯ Daily ◯ Weekly ◯ Monthly ◯ Occasionally ◉ Missing

PART 2: NURSE'S ASSESSMENT

A. CHILDHOOD DEVELOPMENT

Were any problems with gross motor development identified:	◯ Yes ◯ No ◉ Missing
If yes, comment:	
Were any problems with fine motor development identified:	◯ Yes ◯ No ◉ Missing
If yes, comment:	
Were any problems with language development identified:	◯ Yes ◯ No ◉ Missing
If yes, comment:	
Were any problems with social development identified:	◯ Yes ◯ No ◉ Missing
If yes, comment:	

Assessment Outcome:

- ◯ Satisfactory
- ◯ Recheck (child not able to be adequately assessed)
- ◯ Known deficit
- ◯ Review (concerns/mild delay)
- ◯ Refer
- ◉ Missing

B. DYNAMICS

Please comment on the interaction between parent/carer and child (if indicated):

Problem identified:	◯ Yes ◯ No ◉ Missing
Behavioural intervention could be of use:	◯ Yes ◯ No ◉ Missing
Comment:	

C. PHYSICAL ASSESSMENT

Weight:	**kg**
Patient's height:	**cm**
Waist circumference:	**cm** (at umbilicus)
Blood pressure (SDB/DBP):	/ (Systollic/Diastolic)
Pulse rate:	
Nurse's suggestion for doctor to review:	

C. VISION

Visual Acuity	○ With glasses ○ Without glasses ◉ Missing R6/ L6/	(Need referral if unable to read 3 symbols on 6/12 line or 2 or more line differences between eyes)

D. ORAL HEALTH

Oral Health	
Are the child's teeth brushed twice daily?	○ Yes ○ No ○ N/A ◉ Missing
If so, who brushes them?	○ Child ○ Parent/Care giver ○ Unsure ◉ Missing
If child brushes their own teeth, are they supervised?	○ Yes ○ No ◉ Missing
Does the child have gum disease?	○ Yes ○ No ◉ Missing
Does the child have dental caries?	○ Yes ○ No ◉ Missing
If yes please specify which stage:	○ Stage 1 ○ Stage 2 ○ Stage 3 ○ Stage 4 ◉ Missing
Other dental problems (please specify):	

PART 3. MEDICAL ASSESSMENT

A. ADOLESCENT HEALTH (Questions directed to the child if over 10 or less than 10 if appropriate

Smoking	
Do you smoke regularly?	○ Yes ○ No ◉ Missing
If Yes, how many per day?	
Alcohol	
Do you drink alcohol?	○ Yes ○ No ◉ Missing
If Yes, how many standard drinks per week?	
Are you concerned that your alcohol intake might be harmful?	○ Yes ○ No ◉ Missing
Caffeine (Coffee, tea, cola, iced coffee, V, Red Bull, other):	○ Yes ○ No ◉ Missing
Drinks per day:	
Other Substances	○ Yes ○ No ◉ Missing
Opiates (heroin, methadone, codeine, endone, MS contin)	○ Yes ○ No ◉ Missing
Cannabis/Yarndi	○ Yes ○ No ◉ Missing

Amphetamines (speed, base, crystal meth, ice, ecstasy, MDMA)	○ Yes ○ No ◉ Missing
Cocaine	○ Yes ○ No ◉ Missing
Hallucinogen (LSD, magic mushrooms)	○ Yes ○ No ◉ Missing
Volatile Substances (paints, glues)	○ Yes ○ No ◉ Missing
Prescription medicine (valium, temazepam)	○ Yes ○ No ◉ Missing
Over the counter medicine (pseudoephedrine)	○ Yes ○ No ◉ Missing
Comments:	
Sexual and Reproductive Health	
Are you sexually active?	○ Yes ○ No ◉ Missing
If Yes, do you use protection?	○ Yes ○ No ◉ Missing
If Yes, specify details:	

B. PHYSICAL EXAMINATION

Eyes

Squint	○ Yes ○ No ◉ Missing

Ears (Tympanic membrane; TM)	**L**	**R**
TM Normal	☐	☐
TM obscured by wax	☐	☐
TM dry perforation	☐	☐
TM wet perforation	☐	☐
Tympanic membrane bulging	☐	☐
Other	☐	☐
Please specify:		

Skin Problems?	○ Yes ○ No ◉ Missing	
Impetigo or boils	○ Yes ○ No ◉ Missing	
Sores (more than three)	○ Yes ○ No ◉ Missing	
Scabies	○ Yes ○ No ◉ Missing	
Ringworm	○ Yes ○ No ◉ Missing	
Other	○ Yes ○ No ◉ Missing	
Please specify:		
Heart		
Cardiac Auscultation	○ Normal ○ Abnormal ◉ Missing	
If abnormal, please specify:		
Respiratory		
Throat examination	○ Normal ○ Abnormal ◉ Missing	
If abnormality detected, please specify:		
Chest examination	○ Normal ○ Abnormal ◉ Missing	
Respiratory illness detected	○ Yes ○ No ◉ Missing	
If abnormality detected, please specify:		
Abdomen (if indicated)		
Abdominal examination	○ Normal ○ Abnormal ◉ Missing	
If abnormality detected, please specify:		
Other examinations conducted:		
How has your mood been over the last month?	Happy?	○ No ○ A little ○ A lot ○ Unsure ◉ Missing
	So sad nothing could make you happy?	○ No ○ A little ○ A lot ○ Unsure ◉ Missing
	So worried or scared you felt sick in the belly?	○ No ○ A little ○ A lot ○ Unsure ◉ Missing
	So angry or wild you could't walk away and cool down?	○ No ○ A little ○ A lot ○ Unsure ◉ Missing

	Like you wanted to harm yourself?	◯ No ◯ A little ◯ A lot ◯ Unsure ◉ Missing
	Peer relations problems identified	◯ Yes ◯ No ◯ Missing
	Comments:	
	If mental health concerns, please specify:	
Known Health Conditions:	☐ Asthma ☐ Rheumatic Heart Disease	

PROBLEM LIST

C. DIAGNOSIS

Was a new diagnosis made?	◯ Yes ◯ No ◉ Missing
If Yes, specify details:	
Significant health problems and issues:	

PART 4: ACTIONS

Was a referral made?	◯ Yes ◯ No ◉ Missing
If Yes, outline	
Was advice given?	◯ Yes ◯ No ◉ Missing
If Yes, outline	
Was medication	

recommended?	○ Yes ○ No ◉ Missing
If Yes, outline	
Were vaccinations provided during this health check?	○ Yes ○ No ◉ Missing
If Yes, outline	
Other intervention?	○ Yes ○ No ◉ Missing
If Yes, outline	
Date of health check:	

Health Check Completed by:

Sign Off

☐ **Completed?** (Select this only when Health Check is complete)

User Name **Password** Save

Health Check Completed by:

Signed:

Date: