Australian Government
Department of Health and Ageing

Medicare Health Assessment for
Aboriginal and Torres Strait Islander People (MBS Item 715)

Adult Health Assessment (15–54)

Use of a specific form to record the results of the health assessment is not mandatory but the health assessment should cover the matters listed in the Explanatory Notes for the health assessment found at www.health.gov.au/mbsonline. The first page of this form can be used as a report of the health assessment.

Patient's Name ..... Male ☐ Female ☐ DOB: ___/___/_____ or Age:_____

Aboriginal ☐ Torres Strait Islander ☐ Aboriginal and Torres Strait Islander ☐

Work status .....

Current contact details

Address .....

Phone .....

Alternative contact details .....

Address .....

Phone .....

Patient Consent

Explanation of health assessment given ☐ Yes

Patient consent for health assessment given ☐ Yes

Date consent was given: ___/___/_____

Consent given for information to be collected by

Registered Aboriginal health worker ☐

Practice nurse ☐

Previous health assessment

Has the patient had a previous health assessment?

No ☐ Yes ☐

Date of last health assessment (if known) ___/___/_____

Service provided by DR .....

PATIENT'S OVERALL HEALTH

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.....

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RISK FACTORS IDENTIFIED AND DISCUSSED WITH PATIENT

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TESTS UNDERTAKEN, RESULTS AND WHAT THEY MEAN

(some results may not be available)

TEST	AVAILABLE RESULTS & WHAT THEY MEAN

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STRATEGY FOR GOOD HEALTH: REQUIRED TREATMENT/SERVICES/HEALTH ADVICE

TREATMENT	HEALTH ADVICE	HEALTH SERVICES NEEDED

ACTION TO BE TAKEN BY PATIENT

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.....

Next appointment with doctor:..... Date: ___/___/_____ Next Health Assessment: ___/___/_____

GP: Dr ..... GP's Signature: ..... Date: ___/___/_____

MEDICAL HISTORY

FAMILY RELATIONSHIP

Does the patient care for someone else? No ☐ Yes ☐ Is the patient cared for by someone else? No ☐ Yes ☐

CURRENT ISSUES	CURRENT RISK FACTORS

ALLERGIES/DRUG INTOLERANCE

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CURRENT MEDICATIONS (including prescription and over the counter and supplied by doctor without prescription)

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RELEVANT FAMILY MEDICAL HISTORY

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IMMUNISATION STATUS (referring to current age/sex schedule)

TYPE	DATE	TYPE	DATE

PHYSICAL ACTIVITY

IDENTIFIED ISSUES	ACTION

NUTRITION

IDENTIFIED ISSUES	ACTION

ALCOHOL, TOBACCO AND OTHER SUBSTANCE USE

IDENTIFIED ISSUES	ACTION

HEARING LOSS

IDENTIFIED ISSUES	ACTION

MOOD (depression and self harm risk)

IDENTIFIED ISSUES	ACTION

SEXUAL AND REPRODUCTIVE HEALTH

IDENTIFIED ISSUES	ACTION

OTHER MEDICAL HISTORY AS INDICATED FOR PATIENT

VISUAL ACUITY (recommended for over 40s) ☐

IDENTIFIED ISSUES	ACTION

ENVIRONMENTAL AND LIVING CONDITIONS

IDENTIFIED ISSUES	ACTION

Other history considered necessary by doctor or collector (eg work environment)

IDENTIFIED ISSUES	ACTION

MEDICAL EXAMINATION

BLOOD PRESSURE:..... ☐ PULSE RATE AND RHYTHM: Normal ☐ Abnormal ☐

IDENTIFIED ISSUES	ACTION

WEIGHT:..... Height:..... BMI:..... Waist circumference (if indicated):.....

IDENTIFIED ISSUES	ACTION

Adult Health Assessment (15–54)

GUMS AND DENTITION: Normal ☐ Abnormal ☐ .....

IDENTIFIED ISSUES	ACTION

EAR AND HEARING: Otoscopy ☐ Whisper test (if indicated) ☐

IDENTIFIED ISSUES	ACTION

URINALYSIS ☐

IDENTIFIED ISSUES	ACTION

OTHER MEDICAL EXAMINATION – AS INDICATED FOR PATIENT

TRICHIASIS ☐

IDENTIFIED ISSUES	ACTION

SKIN ☐

IDENTIFIED ISSUES	ACTION

OTHER EXAMINATIONS CONSIDERED NECESSARY BY GP

EXAMINATION	IDENTIFIED ISSUES	ACTION

INVESTIGATIONS AS REQUIRED

INVESTIGATION	TESTS DONE	TESTS ORDERED	ARRANGEMENTS (eg referral details)
Fasting blood sugar	☐	Date: ___/___/_____	
Lipids	☐	Date: ___/___/_____	
Pap Smear	☐	Date: ___/___/_____	
STI	☐	Date: ___/___/_____	
Mammography	☐	Date: ___/___/_____	

Other:.....

.....

ASSESSMENT OF PATIENT

(based on consideration of evidence from patient history, examination and results of any investigation)

EXISTING HEALTH ISSUES	IDENTIFIED RISK FACTORS

INTERVENTION ACTION

HEALTH ADVICE PROVIDED TO PATIENT

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OTHER ACTION (if any)

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