# *Health Audit Tool*

**Name:** _____ **Age:** _____ **D.O.B:** ____/____/____

**Weight:** _____ kg **Height:** _____ cm **Waist:** _____ cm

| | | Diabetes | Heart | Kidneys | Lungs |
|---|---|---|---|---|---|
| **Circle the number or dash that applies to each answer.** | | | | | |
| What is your gender? | male | 1 | 1 | – | – |
| | female | – | – | – | – |
| How old are you? | under 40 | – | – | – | – |
| | 40 + years | 1 | 1 | 1 | 1 |
| Are you of Aboriginal or Torres Strait Islander background? | yes | 1 | - | 1 | – |
| | no | – | – | – | – |
| Do you currently have diabetes (type 1 or 2)? If yes, you do not need to complete the green column (for all questions). | yes | – | 1 | 1 | – |
| | no | – | – | – | – |
| Do you have heart disease or have you ever experienced a heart attack or stroke? If yes, you do not need to complete the red column (for all questions). | yes | – | – | 1 | – |
| | no | – | – | – | – |
| Do you have kidney disease (also known as renal impairment)? If yes, you do not need to complete the blue column (for all questions). | yes | – | 1 | – | – |
| | no | – | – | – | – |
| Do you have COPD, COAD or emphysema? If yes, you do not need to complete the yellow column (for all questions). | yes | – | – | – | – |
| | no | – | – | – | – |
| Have your parents, brothers or sisters ever been diagnosed with: | diabetes? If yes, circle → | 1 | – | – | – |
| | heart disease? If yes, circle → | – | 1 | – | – |
| | kidney disease? If yes, circle → | – | – | 1 | – |
| | no, none of the above. | – | – | – | – |
| Have you ever been found to have high blood sugar e.g. during illness, routine blood tests or pregnancy? | yes | 1 | – | – | – |
| | no | – | – | – | – |
| Do you take medication for high blood pressure? | yes | 1 | 1 | 1 | – |
| | no | – | – | – | – |
| Have you ever been diagnosed with an acute kidney injury? | yes | – | – | 1 | – |
| | no | – | – | – | – |
| Do you smoke cigarettes or other tobacco? | yes | 1 | 1 | 1 | 1 |
| | ex-smoker | – | – | – | 1 |
| | no | – | – | – | – |
| Do you cough several times on most days? | yes | – | – | – | 1 |
| | no | – | – | – | – |
| Do you bring up phlegm or mucus on most days? | yes | – | – | – | 1 |
| | no | – | – | – | – |
| Do you get more out-of-breath than others your age? | yes | – | – | – | 1 |
| | no | – | – | – | – |
| Do you exercise often e.g. 30+ minutes on most days? | yes | – | – | – | – |
| | no | 1 | 1 | – | – |
| Are you carrying extra fat around your waistline? *(e.g. "spare tyre")* | yes | 2 | 1 | 1 | – |
| | no | – | – | – | – |
| Have you been told by your doctor that your cholesterol is high or above normal range? | yes | – | 1 | – | – |
| | no | – | – | – | – |
| **Total score (for each column)** | | | | | |

Please complete this form while you are waiting, and hand it to your doctor or nurse when you are called in.