

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)? <small>If yes, you do not need to complete the green column (for all questions).</small>	yes	-	1	1	-
	no	-	-	-	-
Do you have heart disease or have you ever experienced a heart attack or stroke? <small>If yes, you do not need to complete the red column (for all questions).</small>	yes	-	-	1	-
	no	-	-	-	-
Do you have kidney disease (also known as renal impairment)? <small>If yes, you do not need to complete the blue column (for all questions).</small>	yes	-	1	-	-
	no	-	-	-	-
Do you have COPD, COAD or emphysema? <small>If yes, you do not need to complete the yellow column (for all questions).</small>	yes	-	-	-	-
	no	-	-	-	-
Have your parents, brothers or sisters ever been diagnosed with: diabetes? If yes, circle → heart disease? If yes, circle → kidney disease? If yes, circle → no, none of the above.		1	-	-	-
		-	1	-	-
		-	-	1	-
		-	-	-	-
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.

Cardiovascular screening criteria reproduced with permission from *Absolute cardiovascular disease management. Quick reference guide for health professionals*. 2012. ©2012 National Stroke Foundation.

Kidney screening criteria adapted with permission from *Chronic Kidney Disease (CKD) Management in General Practice* (3rd edition). Kidney Health Australia, Melbourne, 2015

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