Annual Medical Review

- This template can assist you to be in control of your health.
- It is long because it covers all the areas that people with physical disabilities commonly experience. It considers people of all different abilities.
- Some topics will NOT be relevant to you. Some topics may be relevant to you however you may not have realised that it could be.
- It is a good idea to answer most topics to find out whether it is something you need to consider. Things also change as you get older.
- Ask your family and those who support you to help you answer the questions.
- NB: if you are a family member or support worker filling in the form, please detail whether you know something to be the case or what you think appears to be the case.
- There are additional prompts to help your GP support you.

Before your annual medical review:

- ☐ Book your GP annual medical review. Book at least a double appointment. Consider asking for a home visit if access is a problem.
- ☐ Ask any other health professionals working with you if there is anything they think your GP should know or needs to followup.
- ☐ Complete the white sections of this template.
- ☐ Ask your GP if they want all information before the appointment.
- ☐ Ask your GP if you need to take any specimens for testing to the appointment.
- ☐ Ask someone you trust and knows you well to come with you if you need support for any reason e.g. advocacy, physical or communication support.

On the day of your appointment:

- ☐ Take this template with you.
- ☐ Take any plans and other important information you have about you or that was requested by your GP.
- ☐ Take a list of your current medications with details of dosage and when you take them.
- ☐ Take any specimens requested by your GP.
- ☐ Take your Medicare card and any other cards if details are not already on file.

During the appointment:

- ☐ Ask your GP to fill in ALL the sections of the review. Explain that it helps you to understand and co-ordinate all your health needs.

After your appointment:

- ☐ Keep the annual medical review information in a safe place so you can look back at it in the future.
- ☐ Complete all actions suggested by your GP.
- ☐ Share relevant information with other health professionals so that everyone is working as a team to support you.

Name	DOB
Completed by	Date

Name:

DOB: **Age:**

Address:

General Practitioner (GP) name and contact details:

Diagnosis:

Complete ALL white boxes before appointment.
Grey sections are for your GP.

Medical concerns over past 12 months / hospitalisations

Significant Past Medical History

Allergies or medication intolerance (please provide a description of reaction)

General Observations	GP Comments / Actions Required
Height	GP: is weight within healthy range?
Weight (include any weight charts for past year)	
Heart rate	
BP	
Skin colour	
Urinalysis	
GP: Findings / Recommendations / Referrals	

Cardiovascular	Yes	No	Comments/Actions Required
Do you get breathless?			
Do you have colour changes to your lips / finger tips / toes?			
Do you suffer from chest pains?			
GP: Do you have any blood pressure concerns?			
GP: Do you have peripheral vascular disease?			
GP: Do you have a cardiac anomaly or history?			
GP: Is there a family history of cardiac disease?			
GP: Is a consultant review required?			
GP: Findings / Recommendations / Referrals			

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Respiratory	Yes	No	Comments/Actions Required
Do you have a history of choking?			
Do you become short of breath?			
Do you have a history of pneumonia?			
Do you have a history of chest infections?			
Do you have a problem clearing oral secretions?			
Do you use a CPAP / BiPAP machine?			
GP: Are there any symptoms of reflux / aspiration?			
GP: Do they have asthma?			
GP: Is there an asthma plan in place? Please update.			
GP: Do they have pulmonary disease?			
GP: Is there a family history of respiratory illness?			
GP: Is a consultant review required? Please consider if multiple antibiotics have been prescribed for infections and / or multiple hospitalisations and / or dysphagia and / or history of reflux / aspiration.			
GP: Is review by physiotherapy and speech therapy required? Please consider for overall respiratory health management and review of swallowing.			
GP: Findings / Recommendations / Referrals			

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Bowels	Yes	No	Comments/Actions Required
Is the pattern of your bowel activity regular? Please circle: Daily / 2nd daily / 3rd daily / only with meds			
Do you have an ileostomy or a colostomy?			
Are you incontinent of faeces?			
Do you complain of PAIN in your stomach region?			
Do you have a bowel management plan in place? (Please attach)			
GP: abdominal examination conducted?			
GP: Do they require aperients or laxatives?			
GP: is there a history of bowel obstructions or abdominal surgery? Any ongoing concerns?			
GP: Is a consultant review required?			
GP: Findings / Recommendations / Referrals			

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Urinary Continence	Yes	No	Comments/Actions Required
Are you incontinent of urine? If yes, how often: rarely / occasionally / always			
Have you always been incontinent?			
Do you have difficulty passing urine?			
Do you appear to pass urine more frequently than is normal? Please attach fluid input / output charts if used.			
Do you have a history of urinary tract infections? How many in past 12 months? Treatment given:			
Do you have a catheter? (circle) suprapubic / indwelling			
Document ongoing management of catheter: Date last changed: Complications / issues:			
GP: Is regular urinalysis or MSU required? How often?			
GP: Have they had / will they have any urological surgery?			
GP: Is a consultant review required?			
GP: Is a continence nurse advisor review required? Please consider if…			
GP: Findings / Recommendations / Referrals			

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Skin Integrity	Yes	No	Comments/Actions Required
Do you have any concerns regarding your skin? (e.g. rash, moles, wounds, acne, dermatitis, psoriasis)			
Do you have any concerns regarding pressure areas?			
Do you require regular dressings to pressure areas? (Describe type of dressings and frequency of change)			
Is there a wound care plan in place? (please attach)			
GP: thorough skin examination performed?			
GP: Any recent mole / lesion checks? Are there skin spots that require further examination?			
GP: is a consultant review required?			
GP: Findings / Recommendations / Referrals			

Endocrinology	Yes	No	Comments/Actions Required
If you have diabetes:			
Do you have a plan and / or medications?			
Do you have any concerns about your diabetes management?			
GP: Is the person diabetic?			
GP: Is there a plan in place?			
GP: Does the person require insulin?			
GP: Do they require a diabetic review?			
GP: Do they have a thyroid condition?			
GP: Do they have another endocrine condition?			
GP: is a consultant review required?			
GP: Findings / Recommendations / Referrals			

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Musculoskeletal	Yes	No	Comments/Actions Required
Do you have concerns about your spine, limbs, joints?			
Has your mobility changed? e.g. not walking as well, having trouble transferring			
Any complaints of PAIN? e.g. neck, back, hips			
Do you take medications regularly for pain?			
Has your regular pain medications been review by your GP?			
Do you have swollen joints?			
Have you been reviewed and explained the above to your physiotherapist / occupational therapist? Attach any documentation.			
GP: Do they have a scoliosis?			
GP: Do they have dislocated or subluxed hips or other joints?			
GP: Do they have osteoporosis?			
GP: Do they have arthritis?			
GP: Reviewed any pain? Reviewed any pain medications?			
GP: Is a consultant review required? Please consider for ongoing management of scoliosis and hip dislocation / subluxation, especially in the presence of pain. Please refer urgently if there are red flags for cervical stenosis.			
GP: Is a physiotherapy and / or occupational therapy review required? Please recommend minimum yearly monitoring reviews for anyone with a physical disability regardless of health and function status. Please prioritise referral in the presence of any musculoskeletal pain. Please recommend regular monitoring for anyone with risk factors for cervical stenosis.			
GP: Is an x-ray or other scan indicated? Please consider monitoring x-rays of hip position and scoliosis, especially in the presence of pain to assist long term management. Please share both the scan and report with physiotherapist.			
GP: Findings / Recommendations / Referrals			

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Neurological	Yes	No	Comments/Actions Required
Do you have any concerns about or have there been any changes with the control of your muscles / spasticity (high tone)?			
Do you take any medications for the control of spasticity (high tone)?			
Have you had any deterioration in your abilities to carry out tasks?			
Do you have any weakness or sensation changes?			
Do you have any recent aggression, confusion or disorientation?			
Have you had a stroke?			
GP: Are there concerns re neurological status?			
GP: Has the person had any neurological surgery?			
GP: Do they have a shunt in situ?			
GP Is a consultant review required? Please consider if spasticity management is required or there has been a deterioration. Please refer urgently if there are red flags for cervical stenosis or C/E signs.			
GP: Is a physiotherapy and / or occupational therapy review required? Please recommend minimum yearly monitoring reviews for anyone with a physical disability regardless of health and function status. Please recommend regular monitoring for anyone with risk factors for cervical stenosis.			
GP: Findings / Recommendations / Referrals			

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Epilepsy	Yes	No	Comments/Actions Required
Do you have seizures?			
Do you have a seizure management plan in place? Please attach.			
Do you have any concerns or has anything changed with regards to your seizures?			
Do you take medications for seizures? Have these been reviewed?			
GP: Have the medications been reviewed in the past 3-6 months?			
GP: Are blood levels required? How often?			
GP: Is a consultant review required?			
GP: Please update seizure management plan annually.			
GP: Findings / Recommendations / Referrals			

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Healthy Lifestyle	Yes	No	Comments/Actions Required
Do you exercise? How often? Type?			
Have you seen a physiotherapist or similar to assist you to exercise or complete physical activity?			
Do you smoke? If yes, how many?			
Do you drink alcohol? If yes, how often?			
Do you need any assistance to help you to lead a healthy lifestyle?			
GP: Is a review by relevant allied health professionals required? E.g. dietitian, physiotherapy, occupational therapy, psychology, social worker, speech therapy, community nursing.			
GP: Findings / Recommendations / Referrals			

Sleep	Yes	No	Comments/Actions Required
Do you sleep well at night?			
Do you need medication to help you sleep? If yes, what?			
Do you snore?			
Do you get tired during the day or fall asleep?			
Have you ever had a sleep assessment completed?			
GP: Is a consultant review required? Please consider if sleep apnoea or respiratory concerns are present.			
GP: Is a review by occupational therapy and / or physiotherapy required? Please consider if sleep problems exist that require a review of the sleep environment, consideration of the 24 hour activity and positioning picture and in the presence of any respiratory and pressure concerns.			
GP: Have medications been reviewed? Is melatonin or sedation medication indicated?			
GP: Findings / Recommendations / Referrals			

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Mental Health	Yes	No	Comments/Actions Required
Do you have any concerns regarding Depression?			
Do you have any concerns regarding Dementia?			
Do you have any concerns regarding Addiction?			
Any challenging behaviours either noted yourself or by those who support you?			
Do you have any plans in place? Please attach.			
Have you seen a psychiatrist, psychologist or social worker in the past 12 months?			
Do you take any medications for your mental health?			
Have your medications been reviewed?			
Any other mental health concerns?			
GP: Have medications been reviewed in the past 3-6 months?			
GP: Are there concerns regarding mental health?			
GP: Is a consultant review required?			
GP: Is referral to psychology and / or social worker or a positive behaviour support team required? Are they receiving services from an agency who has social work or psychology support?			
GP: Findings / Recommendations / Referrals			

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Hearing and Vision	Yes	No	Comments/Actions Required
Do you have concerns regarding your hearing?			
Do you have any ear discharge?			
Have you been reviewed by an audiologist or another specialist in the past year?			
Do you have any concerns regarding your vision?			
Is eye care necessary?			
Have you been reviewed by an optometrist / ophthalmologist in past year?			
GP: otoscope – ear check completed?			
GP: vision and eye check completed?			
GP: is a consultant review required?			
GP: Findings / Recommendations / Referrals			

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Nutrition	Yes	No	Comments/Actions Required
Do you have a special diet or dietary restrictions?			
Do you take nutritional supplements?			
Do you cough when eating or drinking?			
Do you have thickened fluids either using a fluid thickening product or naturally thicker fluids?			
Do you have any concerns about the amount of fluids you have each day?			
Do you have a gastrostomy tube? E.g. PEG Please state tubing size and date of last change.			
Do you experience pain during or after eating?			
Do you have reflux?			
Have you seen a dietitian in the past 12 months?			
Have you seen a speech pathologist in the past 12 months?			
GP: Do they have any reflux concerns / GORD?			
GP: Is a dietitian review required? Please consider if weight concerns exist or there is a risk of under or over weight, supplementation requirements or tube feeding.			
GP: Is a speech therapy review required? Please recommend minimum yearly reviews for people with physical disabilities if there are any risk factors for swallowing regardless of whether any swallowing problems occur, especially from 30 years of age.			
GP: Is a physiotherapy and / or occupational therapy review required? Please consider if positioning over 24 hours could assist reflux or swallowing management. Please consider if there is a respiratory component. Please consider if exercise / physical activity needs to implemented.			
GP: medication review completed?			
GP: Is a consultant review required?			
GP: Findings / Recommendations / Referrals			

Name	**DOB**
Completed by	**Date**

Dental Care	Yes	No	Comments/Actions Required
Do you receive regular dental care check-ups?			
Do you have any dental concerns or problems cleaning your teeth?			
Do you have any pain in your mouth, teeth or gums?			
Dentist location:			
GP: Findings / Recommendations / Referrals			

Women's Health Check	Yes	No	Comments/Actions Required
Is your menstrual (period) cycle regular?			
Are you on any medications for menstrual (period) management?			
Has medications for menstrual (period) management ever been discussed or considered?			
If relevant, have you had preventative health checks? e.g. pap smear, breast check			
Do you have any abnormalities around your breast area e.g. lumps, pitting, bruising, redness, swelling, pain, discharge			
Do you have any other concerns?			
GP: menstruation review completed?			
GP: contraceptive review completed?			
GP: breast examination completed?			
GP: pap smear due and / or completed?			
GP: mammogram due and / or referred? (over 50 years, every two years)			
GP: If sexually active:			
Contraception discussed?			
Safe sex advice offered?			
Screening required?			
GP: Is a consultant review required?			
GP: Findings / Recommendations / Referrals			

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Men's Health Check	Yes	No	Comments/Actions Required
Any concerns? Details:			
GP: Testicular check performed?			
GP: Are there any indicators of prostate problems?			
GP: If sexually active:			
Contraception discussed?			
Safe sex advice offered?			
Screening required?			
GP: Is a consultant review required?			
GP: Findings / Recommendations / Referrals			

Immunisation	Yes	No	Comments/Actions Required
Teenagers: have you completed the recommended childhood immunisation schedule?			
Have you had a flu vaccination this year? Date:			
Have you had any of the following?			
Hep B vaccination. Date:			
Diphtheria, Tetanus, Whooping Cough (in past 10 years). Date:			
Pneumovax. Date:			
Any other vaccinations. Dates.			
GP: is an annual influenza vaccination recommended?			
GP: is Hep B vaccination recommended?			
GP: Any other vaccinations recommended?			
GP: Findings / Recommendations / Referrals			

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Medication Review	Yes	No	Comments/Actions Required
Do you organise and take your own medications?			
Do you have someone help you in any way with your medications?			
Do you have any problems taking your medication?			
If you have thickened fluids or modified foods, have you seen a speech therapists for a review of your swallowing when taking medications?			
Do you modify your medications when taking them? E.g. crushing.			
GP: have all medications been reviewed? Please detail how often medications should be reviewed: 6 monthly / annually?			
GP: Is a home medicine review required?			
GP: Would use of a medicine pack be beneficial?			
GP: Findings / Recommendations / Referrals			

Blood Tests	Yes	No	Comments/Actions Required
GP: note blood tests / tests needed:			
FBC			
LFT			
Blood Drug Levels			
TFT			
Fasting BSL			
Lipids			
Electrolytes			
Other:			
GP: Findings / Recommendations / Referrals			

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Future Health Plans	Yes	No	Comments/Actions Required
Do you have an Advanced Health Directive?			
If yes, does it need reviewing?			
If no, have you considered it and talked to your GP?			
Do you have any specific health requirements that need documenting?			
Do you have any palliative care needs?			
GP: Findings / Recommendations / Referrals			

Other Medical Conditions	Needs Action	Plan in Place	Family History	Comments / Actions Required
Renal				
Cancer				
Hernial				
Other				

Performed by:

GP name: Date:

GP signature

Medical Practitioner Stamp if available

Summary of GP Findings / Recommendations / Referrals to Action

Issue	Action	Who will help you	Tick when completed

Name	**DOB**
Completed by	**Date**