



44515

Mother's Assessment Form - 16 year Follow-up

Date of Examination: _____ / _____ / _____

RA _____

Weight: _____ . _____ kg

Height: _____ . _____ cm

L Arm Circ: _____ . _____ cm

BP / Heart Rate:

1. _____ / _____ MmHg Heart Rate: _____ State: _____ Dinamap: 1

2. _____ / _____ MmHg Heart Rate: _____ State: _____ 2

3. _____ / _____ MmHg Heart Rate: _____ State: _____ 3

4. _____ / _____ MmHg Heart Rate: _____ State: _____ 4

Av. _____ / _____ MmHg Heart Rate: _____ State: Referred to GP

Pregnant: Yes No NA Not stated

Cholesterol Lowering Spreads: Yes No Not stated

Medications: Taken/used regularly over the last 4 weeks
(Prescription, over the counter and health food products)
(Tablets, creams or suppositories)

	A.	B.	C.	D.	E.	F.
1.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
4.	<input type="checkbox"/>					
5.	<input type="checkbox"/>					
6.	<input type="checkbox"/>					
7.	<input type="checkbox"/>					
8.	<input type="checkbox"/>					
9.	<input type="checkbox"/>					

- 1. Antihypertensive drugs: A = ace inhibitor; B = diuretic; C = all antagonist; D = B-blocker; E = ca channel blocker; F = other
- 2. Hypoglycaemic agents: A = insulin; B = other; C = metformin
- 3. Lipid lowering agents: A = fibrates; B = statins; C = fish oil; D = other (eg. **lipid lowering spreads** - Logicol, Proactive)
- 4. Non-steroidal anti-inflammatories
- 5. Asprin
- 6. Multivitamins
- 7. Iron compounds / Haemophoetic agents
- 8. Antidepressants / Anti-anxiety
- 9. Other

Date of Bloods: _____ / _____ / _____ RA _____



44515

Father's Assessment Form - 16 year Follow-up

Date of Examination: _____ / _____ / _____

RA _____

Weight: _____ . _____ kg

Height: _____ . _____ cm

L Arm Circ: _____ . _____ cm

BP / Heart Rate:

- | | | | |
|-----------------------|-------------------|--------------|-------------------------------------|
| 1. _____ / _____ MmHg | Heart Rate: _____ | State: _____ | Dinamap: <input type="checkbox"/> 1 |
| 2. _____ / _____ MmHg | Heart Rate: _____ | State: _____ | <input type="checkbox"/> 2 |
| 3. _____ / _____ MmHg | Heart Rate: _____ | State: _____ | <input type="checkbox"/> 3 |
| 4. _____ / _____ MmHg | Heart Rate: _____ | State: _____ | <input type="checkbox"/> 4 |

Av. _____ / _____ MmHg Heart Rate: _____ State: Referred to GP

Cholesterol Lowering Spreads: Yes No NA Not stated

Medications: Taken/used regularly over the last 4 weeks
(Prescription, over the counter and health food products)
(Tablets, creams or suppositories)

	A.	B.	C.	D.	E.	F.
1. _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
3. _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
4. _____	<input type="checkbox"/>					
5. _____	<input type="checkbox"/>					
6. _____	<input type="checkbox"/>					
7. _____	<input type="checkbox"/>					
8. _____	<input type="checkbox"/>					
9. _____	<input type="checkbox"/>					

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- 8. Antidepressants / Anti-anxiety
- 9. Other

Date of Bloods: _____ / _____ / _____ RA _____