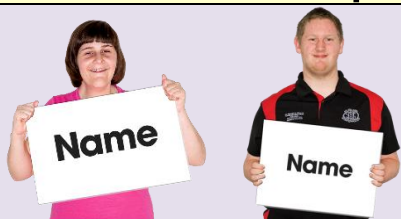


Getting ready for your Annual Health Check

Annual Health Checks are:
To help you stay well and healthy



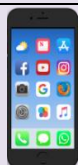
Name:



Address:



Date of birth:



Phone:



Email:



Living Status:

Supported Living

With Family

Alone

Nursing Home

Other

Work:





Respite/ Short Stay:





Consent to sharing information

Consent is being asked if you agree to something.
This means saying yes or no.


Please circle

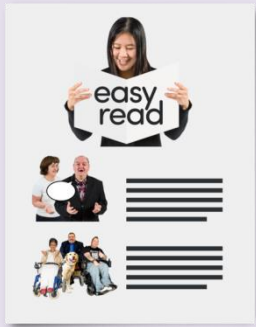



		1. Consent for electronic record sharing?
		2. Consent to share data with another Professional? (Someone who works to help you)



		1. I am not able to consent to sharing my information.
		2. It has been agreed that it is in my Best Interest to share information.



Reasonable Adjustments

A reasonable adjustment is a change your Doctor needs to make so going to the surgery is easier for you. **Please tick the box's  for ways we can help you.**


	I need easy read Documents.		
	I need information in Braille		
	I need information in Large print.		
	I need an interpreter.		


	I use a wheelchair and I will need a hoist if I need a physical examination.		
	I may need a home visit .		

 	I would like to come at quiet times , because I find it difficult waiting for my appointment.		
	I may need to wait outside until you are ready to see me.		
	Bright lights or loud Noises may affect me. I may need to sit in a quiet room.		

	I need longer Appointments		
	I need support with medical procedures. Like having an injection , blood test or blood pressure test.		Ways you can support me.....

			How I have tolerated these tests in the past....
--	--	--	--

	My carer will support you to understand my needs.		
	I get very nervous at appointments and need my carer to support me.		
	Please tell my carer about any appointments.		

	These are the other things that will help me....



Weight

(putting on weight or losing weight)



Do you have a Chronic illness?

Are you on the appropriate pathway?



Is the cause of the Learning Disability Known?

Have you ever had a genetic investigation?

Please **circle** Yes  or No 
to **tell** the doctor any **problems** and what is **important** for you



Flu

Yes

No

Your notes...



Have you had your **nasal spray** or **flu vaccine injection**?

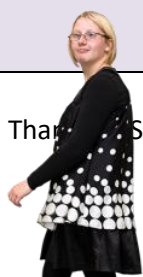



Mobility




Yes

No









Your notes...







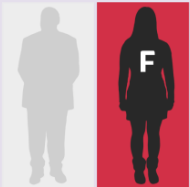



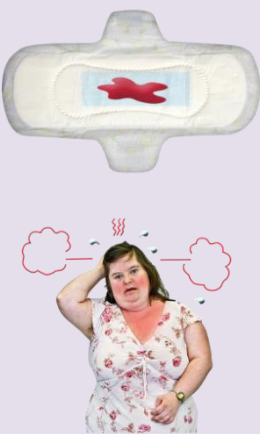
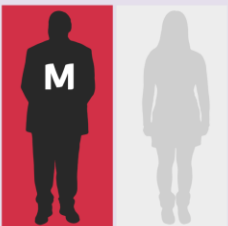

	moving			
	Stiffness or difficulty moving	✓	✗	
	Pain when moving	✓	✗	
	Falling or tripping	✓	✗	
	Changes in posture / mobility	✓	✗	
	Swelling or redness in limbs / skin	✓	✗	
	Mobility equipment used	✓	✗	



	Being Healthy	Yes ✓	No ✗	Your notes... 
	Diet Do you eat fruit and vegetables?	✓	✗	





	Exercise Do you exercise?			What exercise do you do?
	Smoking Do you smoke?			
	Alcohol Do you drink alcohol?			How much alcohol do you drink?
	Drugs Do you take illegal drugs?			






	Sexual Health & Contraception	Yes 	No 	Your notes... 
	Do you have sex?			
	Do you use contraception?			


	Bowel Cancer check	Yes 	No 	Your notes... 
--	---------------------------	---	--	---





	Are you aged 60-74?	✓	✗	
	If yes, have you received your bowel test kit?	✓	✗	
	Female health checks	Yes ✓	No ✗	Your notes... 
	Do you check your breasts?	✓	✗	
	Have you seen or felt changes to your Breasts?	✓	✗	
	Have you had Breast screening (age 50+)	✓	✗	
	Have you had a smear test?	✓	✗	Date:
	Change in periods e.g. heavy bleeding in between periods	✓	✗	
	Painful periods	✓	✗	
	Vaginal discharge	✓	✗	
	Menopause symptoms	✓	✗	
	Male health checks	Yes ✓	No ✗	Your notes... 

 Testicles	Do you check your testicles?	✓	✗	
	Have you seen or felt changes to your testicles?	✓	✗	
	Have you had your Abdominal Aortic Aneurysm or AAA check? (Age 65 +)	✓	✗	

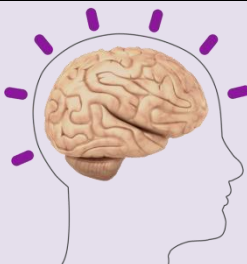

 Eye	Eyes	Yes ✓	No ✗	Your notes... 
	When did you have your eyes tested?	✓	✗	Date:
	Do you have any eyesight problems or wear glasses?	✓	✗	
 Ear	Ears	Yes ✓	No ✗	Your notes... 
	Have you noticed any problems or changes to your hearing?	✓	✗	
	Have you had an ear test?	✓	✗	Date:

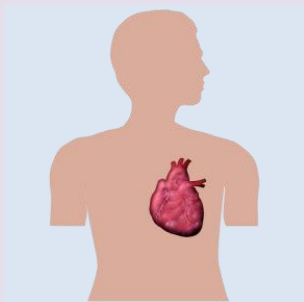

 	Teeth	Yes ✓	No ✗	Your notes... 
	Do you have a dentist?	✓	✗	
	When was your last visit?			Date:
	Do your teeth hurt?	✓	✗	
	Do your gums bleed?	✓	✗	
	Do you have a swelling or a lump?	✓	✗	
	Respiratory	Yes ✓	No ✗	Your notes... 
	Chest & Breathing			
	Is it hard to breathe?	✓	✗	
	Coughing that won't go away	✓	✗	
	Chest infections	✓	✗	
	Coughing up blood	✓	✗	





	Unusual coloured spit	✓	✗	
	Wheeze	✓	✗	
	Hay fever, allergies, asthma	✓	✗	

	Bowels and Poo	Yes ✓	No ✗	Your notes... 
	Constipation – hard poo or can't poo	✓	✗	
	Watery poo and going too much	✓	✗	
	Bleeding from your bottom	✓	✗	
	Difficulty getting to the toilet on time	✓	✗	
	Changes in having a poo	✓	✗	
	Indigestion	✓	✗	
	Urine	Yes ✓	No ✗	Your notes... 
	Pain when you pee?	✓	✗	
	Have you had a urine infection?	✓	✗	
	Pee more often?	✓	✗	
	Do you find it difficult	✓	✗	



	to start Peeing?			
	Start and stop when peeing?	✓	✗	
	Blood in your pee	✓	✗	
	Difficulty getting to the toilet on time?	✓	✗	



	Epilepsy Brain	Yes ✓	No ✗	Your notes... 
	If you have epilepsy please answer these questions			
	Please bring your seizure chart with you, if you have one.			
	How many seizures per month?	✓	✗	
	Any changes to seizures?	✓	✗	
	Are you under the care of a specialist (neurologist)?	✓	✗	When did you last see them?
	Do you take your epilepsy medication when you should?	✓	✗	
	Do you have any side effects i.e. feeling dizzy, sick, irritable or have blurred vision?	✓	✗	


	Heart	Yes ✓	No ✗	Your notes... 
	Is it difficult to breath?	✓	✗	
	Do you have chest pain when exercising?	✓	✗	
	Any swelling to the ankles, hands or body?	✓	✗	



	Diabetes	Yes ✓	No ✗	Your notes... 
	If you have diabetes please answer these questions			
	Please bring your blood sugar charts if you have them			
	Do you test your blood sugar regularly?	✓	✗	
	Do you have any problems with your eye sight?	✓	✗	
	Have you been for your diabetic eye test?	✓	✗	
	Feet	Yes ✓	No ✗	Your notes... 
	Have you been to a podiatrist or foot specialist?	✓	✗	If yes when did you go?

	If no, who cuts your nails?	✓	✗	
	Do you have any pain in your feet?	✓	✗	

	Pain	Yes ✓	No ✗	Your notes... 
	Do you have any pain?	✓	✗	
	Does your pain medicine help?	✓	✗	

	Skin	Yes ✓	No ✗	Your notes... 
	Dry or Itchy Skin	✓	✗	
	Changes to moles	✓	✗	
	Cold Sores	✓	✗	
	Sores or open wounds	✓	✗	
	Changes to the colour of your skin?	✓	✗	

	Mental Health	Yes ✓	No ✗	Your notes... 
	Feeling low, sad or	✓	✗	

	unhappy?			
	Feeling worried, frightened or anxious?	✓	✗	
	Do you feel like crying?	✓	✗	
	Do you feel like you can't cope?	✓	✗	
	Do you feel irritable, aggressive or violent?	✓	✗	
	Think about hurting yourself or actually hurt yourself?	✓	✗	
	Sleeping too much or not sleeping	✓	✗	
	Do you hear voices or see things?	✓	✗	
	Worries about your memory? or confusion?	✓	✗	
	Have you spoken to someone about how you feel?	✓	✗	
	<h2>Medication Review</h2> <p>Your Doctor will talk to you about your medicines and look at whether your medicines are right for you.</p>			
	Do you have any concerns or questions about your medication?	✓	✗	



My Hospital Passport

Help hospital staff understand how to help you

Do you have a Hospital Passport?



Do you have any Questions?

Is there anything you want the Doctor or Nurse to know?



Health Action Plan

At the end of your Annual Health Check **you** should **get** a copy of your **Health Action Plan**.





Thank you for filling out this form

Please send it back to your GP before your Annual Health Check appointment.