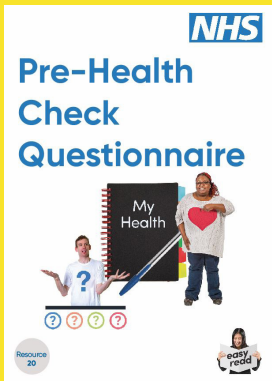




Pre-Health Check Questionnaire



About this booklet



Please fill in this booklet before you come to your Annual Health Check. You may want to ask for help from family, a friend or a support worker.



Please bring all of your medicines with you, whether they are prescribed by the doctor or not.



Please bring your Health Action Plan, if you have one. Please also bring a urine (wee) sample.



What is the date of your Heath Check?

DAY	MONTH	YEAR

About me



Name

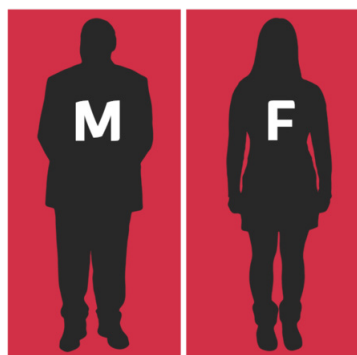


Date of birth

DAY

MONTH

YEAR



☐ Male ☐ Female ☐ Other (please write in box below)



Address

Where I live



Please tell us about where you live.

1. What kind of place is it?



☐ Your family home



☐ A residential care home



☐ Your own flat or house



☐ Supported living home

Employment

2.a. Do you have a job?



Yes



No



2.b. If **yes**, what is your job?

Medical phobias / fears



3.a. Do you have any medical fears/phobias?

Yes



No



3.b. If **yes**, what?



My Learning Disability



4. Does your type of learning disability have a **name**? If you do not know, leave the box blank



5. Were you born with the learning disability or did something cause it? If you do not know, leave the box blank

My Communication



6. The language I speak and understand is:



7. How do you communicate?
(tick as many as you like)



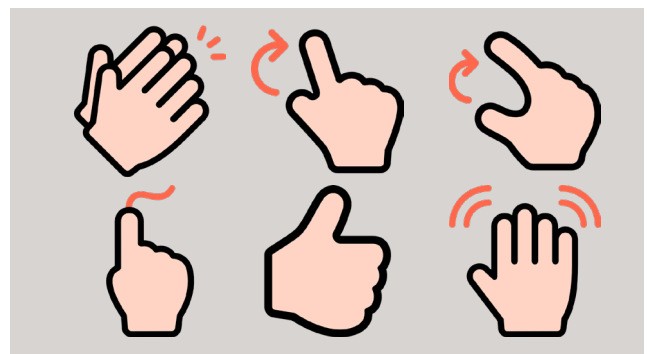
☐ Talking



☐ Signing

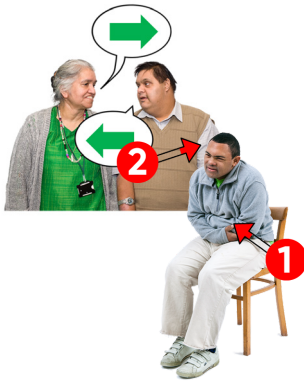


☐ Using a communication aid



☐ Pointing and gestures

My Communication

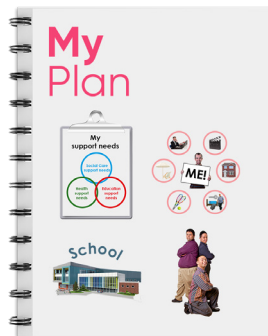


8.a. Can you easily tell people if you are ill or in pain?

Yes



No



8.b. **If no,** is this written in a support plan?

Yes



No



Speech &
Language
Therapy



9. Do you see a speech therapist to help with your communication?

Yes



No



My Communication



10. Do you have any difficulty in communicating?

Yes



No



10.b. If **yes**, what helps you to communicate?



My diet



11 Do you have any difficulties eating, drinking or swallowing?

Yes



No



11.b. If **yes**, what helps you eating, drinking or swallowing?

A large grey rectangular box for text input, intended for the user to describe what helps them with eating, drinking, or swallowing.

Speech &
Language
Therapy



11.c. Do you see a speech therapist about this difficulty?

Yes



No



12. Do you have any burning pain in your chest?
(heartburn or indigestion)

Yes



No





12. Has your appetite changed recently?

Yes ☐

No ☐



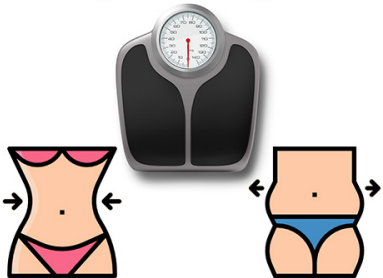
13. Do you see a dietitian?

Yes ☐

No ☐

Weight & appetite

My weight



14. Are you worried about your weight
(either putting on too much weight or losing weight)?

Yes ☐

No ☐

Exercise



15. What exercise do you do?

Alcohol



16.a. Do you drink alcohol?

Yes



No



16.b. If **yes**, how much do you drink each week?

units a week

Examples of units in common alcoholic drinks



Pint of lager
2.6 units



**175ml glass
of wine**
2.3 units



25 ml of spirit
1 unit



**275 ml of
alcopop**
1.1 units



17. Do you want help to drink less alcohol?

Yes



No



Smoking



18.a. Do you smoke?

Yes ☐ No ☐



18.b. If **yes**, how many cigarettes do you smoke a day?



19. If you smoke, would you like help to stop smoking?

Yes ☐ No ☐

My breathing



20. Do you have any problems with your breathing?

Yes ☐ No ☐



21.a. Do you cough?

Yes ☐ No ☐

↓



21.b. If **yes**, do you cough up anything?

Yes ☐ No ☐





21.c. If **yes**, what do you cough up?
And how often?

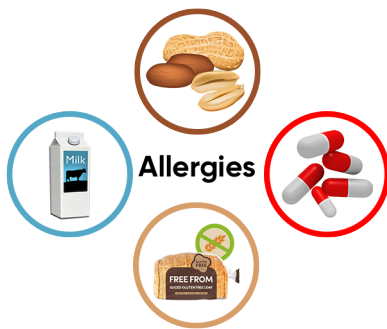
Tablets and medicines not from your doctor



22. Do you take any tablets or medicines that are not from your doctor (things like vitamins, painkillers, laxatives)?

Yes ☐ No ☐

My allergies



23.a. Do you have any allergies?

Yes ☐ No ☐



23.b. If **yes**, what are you allergic to?



Memory



24. Do you or your carer think there has been a change in your memory?

Yes ☐ No ☐

My eyesight



My vision

25. Do you have any problems with your eyes or difficulty seeing things?

Yes



No



26. What was the date of your last optician's appointment (if you are not sure, leave blank)?

DAY

MONTH

YEAR

My hearing



27. Do you have any difficulty hearing?

Yes ☐

No ☐



28.a. Do you have a hearing aid?

Yes ☐

No ☐



28.b. If **yes**, do you wear it?

Yes ☐

No ☐



29.a. Do you visit an audiologist (someone who helps with hearing and balance problems)?

Yes ☐

No ☐



29.b. If **yes**, what was the last date of your last appointment?

DAY

MONTH

YEAR

My teeth



30.a. Do you have any problems with your teeth, gums or mouth?

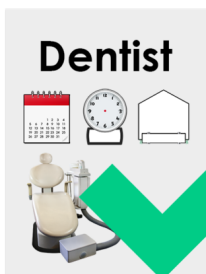
Yes ☐ No ☐



30.b. If **yes**, what?



31. Which dentist do you go to?



32. Do you go to the dentist regularly?

Yes ☐ No ☐



33. What was the date of your last dental appointment?

DAY	MONTH	YEAR

My mobility



34. Are you able to move around easily?

Yes ☐

No ☐



35. Any comments about your mobility



36.a. Do you use mobility aids (these are things like a wheelchair, a stick or a frame)?

Yes ☐

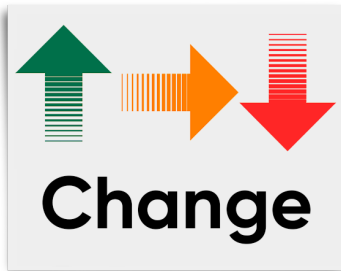


No ☐

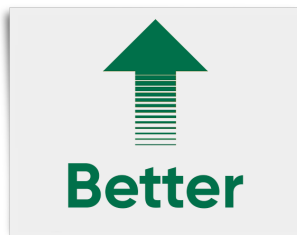


36.b. If yes, what mobility aid(s) do you use?

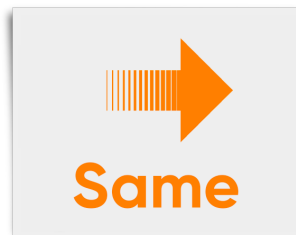
My mobility



37. Has your mobility changed in the last year?



It's better ☐



It's the same ☐



It's worse ☐



38. Do you see a **physiotherapist** (physiotherapists work with people to help with a range of problems which affect your movement)?

Yes ☐

No ☐



39. Do you see an **occupational therapist** (occupational therapists help people of all ages to carry out everyday activities which are essential for health and wellbeing)?

Yes ☐

No ☐

My feet



40.a. Do you have any problems with your feet?

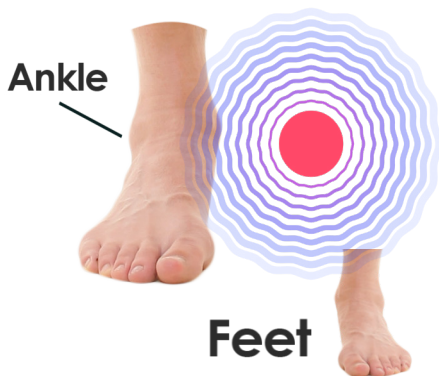
Yes



No



40.b. If yes, what?



41. Do you have swelling of your ankles or feet?

Yes



No



42.a. Do you visit the podiatrist or chiropodist (someone who can help with common foot problems)?

Yes



No



42.b. If yes, what was the date of your last appointment?

DAY

MONTH

YEAR

Hair, skin and nails



43.a. Do you have any problems with your hair, skin or nails?

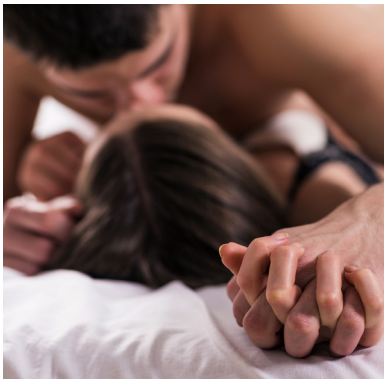
Yes ☐ No ☐





43.b. If yes, what?

Sex



44. Do you have sex?

Yes ☐ No ☐



45. Do you use contraceptives (These are things that stop a women getting pregnant)?

Yes ☐ No ☐

My sleep



46. Do you have problems sleeping?

Yes



No



Epilepsy



47.a. Do you have epilepsy?

Yes



No



47.b. If **yes**, do you know what kind of epilepsy you have?

Specialists



48. Do you see a specialist doctor or nurse for your epilepsy?

Yes



No



Epilepsy



49. In the last year, have you started to shake or have movements you cannot control?

Yes



No



50. Have people noticed that sometimes you are not concentrating (for example, having absences)?

Yes



No



Drugs



51.a. Do you use drugs (for example cannabis or ecstasy)?

Yes



No



51.b. If yes, do you want help to stop using these drugs?

Yes



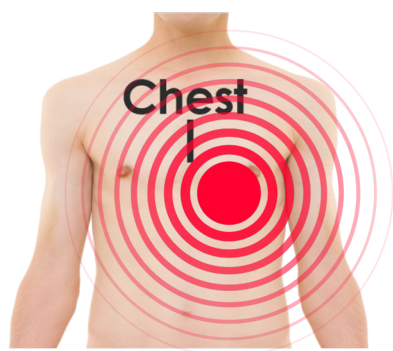
No



Pains



52. How would someone know you are in pain?



53.a. Do you get any pain in your chest?

Yes



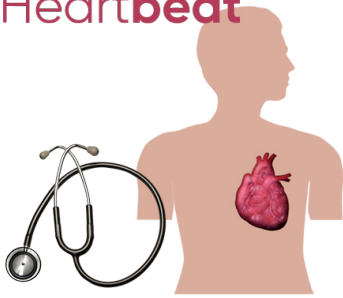
No



53.b. If **yes**, when does the pain happen?

Pains

Heartbeat

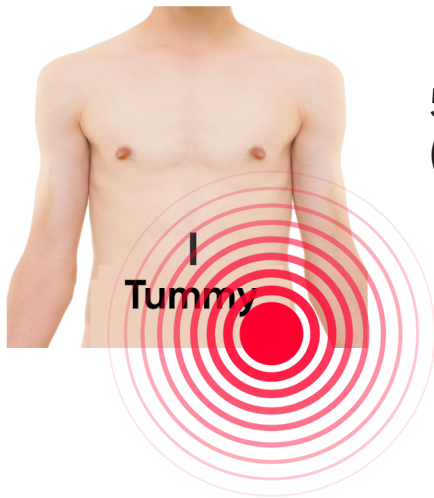


54. Do you feel you have an uneven heart beat or your heart beats fast?

Yes



No

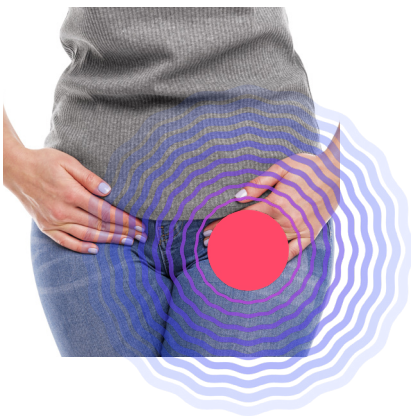


55. Do you have any pain in your abdomen (tummy)?

Yes



No



56. Have you got any swellings in your groin (just above the crease at the top of your leg)?

Yes



No



Continence



57. Do you have any constipation or diarrhoea?

Yes ☐

No ☐



Poo

58. Do you have any problems with faecal (poo) incontinence?

Yes ☐

No ☐



Wee

59. Do you have any problems with urinary (wee) incontinence?

Yes ☐

No ☐



60. Does it hurt when you wee?

Yes ☐

No ☐

Continence



61. Is there any blood in your wee?

Yes ☐

No ☐



62. Do you have any other problems when you wee (things like going to toilet the a lot)?



63. Do you see a continence nurse (This is someone who can look at causes, create treatment plans and empower people who can't always control when they go to the toilet)?

Yes ☐

No ☐



64.a. Do you have continence aids (things like pads or medicine)?

Yes ☐

No ☐



64.b. If yes, what?

Any other health conditions

65. **Do you have any other health conditions** (If you don't, leave the box blank)?

My Family

Family



66.a. **Are there any medical problems or illnesses that run in your family?**

Yes



No



66.b. **If yes, what?**

My Mental Health



67. Do you feel anxious or worried a lot of the time?

Yes ☐

No ☐



68. Do you feel sad for long periods of time and find it difficult to cheer yourself up?

Yes ☐

No ☐



69. Do you get angry and shout at people a lot?

Yes ☐

No ☐



70. Do you ever try to hurt yourself?

Yes ☐

No ☐

My Mental Health



71. **Do you see a psychiatrist** (this is someone who specialises in the prevention, diagnosis, and treatment of mental illness)?

Yes ☐

No ☐



72. **Do you have support from the mental health team?**

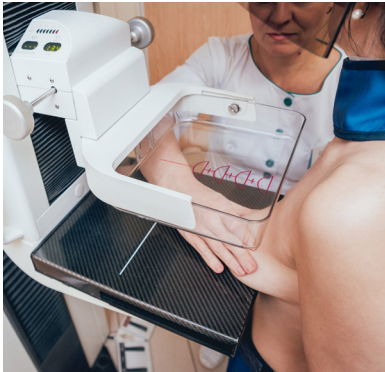
Yes ☐

No ☐



73. **Do you have any other comments about your mental health?**

For Women



74.a. **If you are over 50** have you been for a breast screening test?

Yes



No



74.b. **If yes,** when was your last test?

DAY

MONTH

YEAR



75.a. **If you are between 25-64** have you had a cervical smear test?

Yes



No



75.b. **If yes,** when was your last test?

DAY

MONTH

YEAR

For Women



76. Do you have periods?

Yes

☐

No

☐

77. Are your periods painful?

Yes

☐

No

☐

78. Is the bleeding very heavy?

Yes

☐

No

☐

79. Do you have any irregular bleeding
- for example bleeding between periods?

Yes

☐

No

☐

For Women



80. Do you have any vaginal discharge that is smelly or makes you sore?

Yes

☐

No

☐

81. Have you noticed any pain or lumps in your breasts?

Yes

☐

No

☐

Men and Women aged 60–69



82.a. **If you are aged between 60 & 69,** have you have been sent a kit to test for bowel cancer?

When?



82.b. **If yes,** when did you last do the test?

DAY

MONTH

YEAR

For Men



83. Has there been any pain or swelling in your testicles?

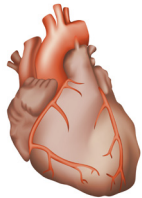
Yes

☐

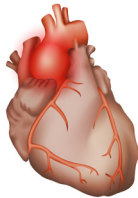
No

☐

Normal heart



Ascending aortic aneurysm



84. **If you are 65 or over**, have you have been for an AAA screening?

Yes

☐

No

☐

FOR GP REFERENCE: SOCIAL

My care and support



85. **If you have support, who supports you** (If you don't have any support, leave the boxes blank)?

Family

Family



Name of family carer

My care and support

Family

Family



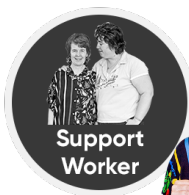
Family carer's contact number

Family



Family carer's e-mail address

Paid support worker / carer



Name of support worker or carer



Support worker's phone number



Support worker's e-mail address

My care and support

Social worker (if you have one)



Name of social worker



Social worker's contact number



Social worker's e-mail address

My care and support to others

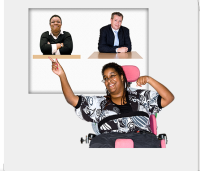


86.a. **Are you a carer for anyone** (this could be for children, parents or a partner)?

Yes ☐ No ☐



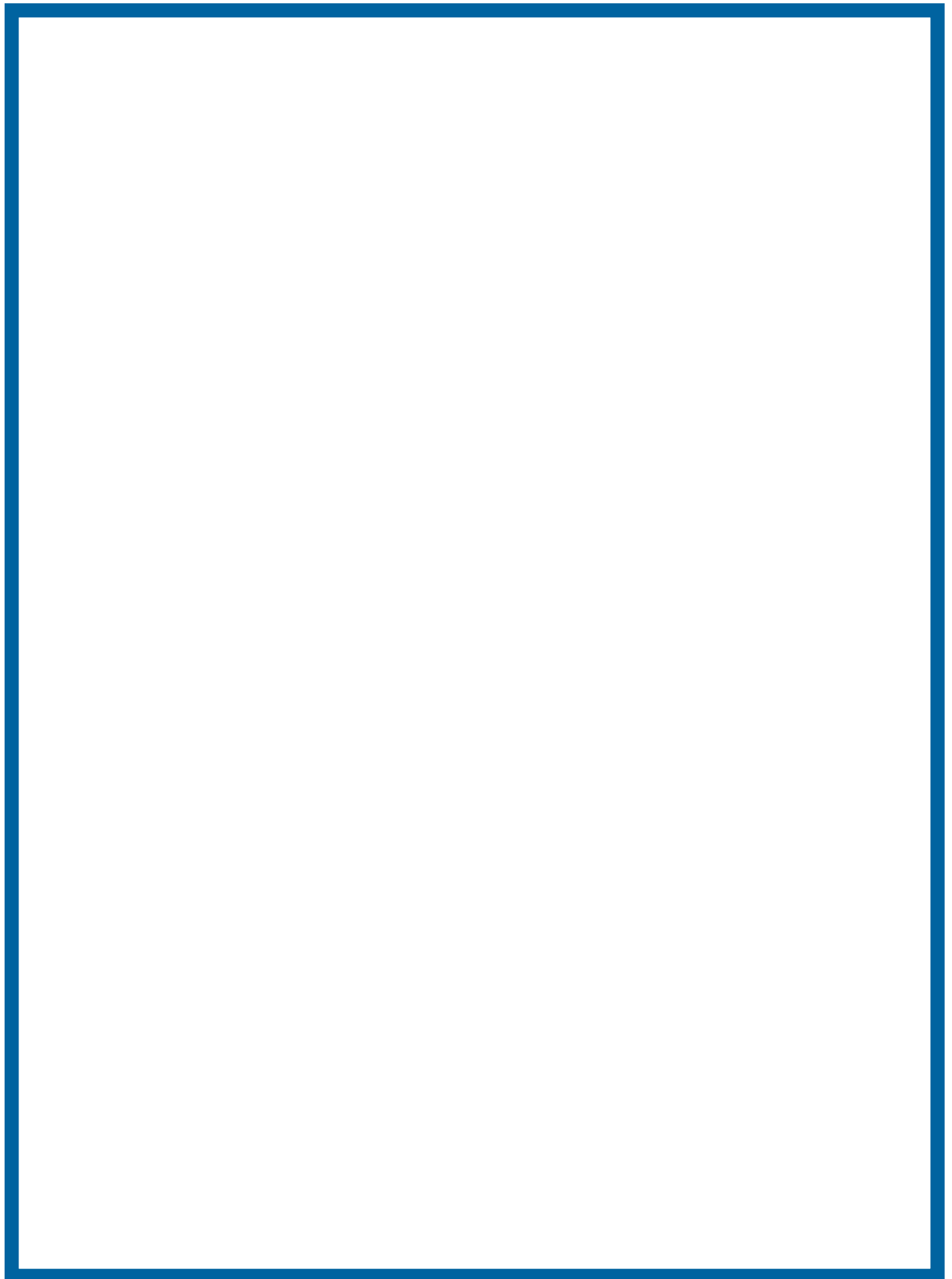
Who?



86.b. If **yes**, who do you care for?

Notes

Notes



Notes

Primary Care Accessible Resources

Resource 20: Pre-Health Check Questionnaire

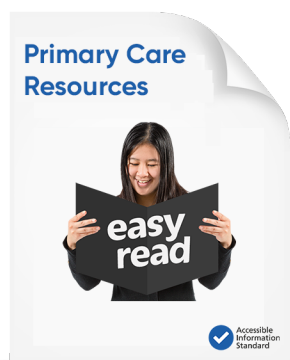
Suffolk Learning
Disability Partnership



This booklet was co-produced by Ace Anglia and members of the 'Staying Healthy, Safe & Well' Workstream of the Joint Suffolk Learning Disability Strategy 2015-20.



The resources were originally funded by clinical commissioning groups in Suffolk. They have been amended for use across Norfolk and Waveney with the permission from Suffolk clinical commissioning groups.



This booklet forms part of a number of information packs on LD health checks that help to explain things about primary care. Other information leaflets that you may find useful are available at your local GP practice.



Designed by: **Ace Anglia: Accessible Information**

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Made using:

