

Questions to answer before your Health Check



Please put 1 tick in a box or write the answer for each question.

It is fine for someone to help you.



My name



1. We would like to share information about you with other health care professionals. They could be people like

- Dentists who check your teeth
- Opticians who check your eyes
- Hospital doctors
- Community Learning Disability Nurses

Is this OK?

Yes

No






2. Are you getting help to fill in this form?



If yes, who is helping you to fill in this form?

Name




3. Do you know your diagnosis? This is the health problem your doctor says you have.

	Yes		No		Don't know
	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>

If yes, please tell us about it:

.....
.....
.....

4. Do you have any other health problems? This could be epilepsy, diabetes or something else.




	Yes		No		Don't know
	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>

If yes, please tell us about it:

.....
.....
.....



5. Have you ever had an operation?

	Yes		No		Don't know
	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>




If yes, please tell us about it:

.....
.....
.....



6. Is there any history of illness in your family?

Yes No Don't know

If yes, please tell us about it:

.....




.....

.....



7. Do you go to a dentist to have your teeth checked?

Yes No Don't know




If yes, when was the last time you went to a dentist?

.....



8. Do you go to an optician to have your eyesight checked?

Yes No Don't know

If yes, when was the last time you went to an optician?

.....



9. Do you go a chiropodist or podiatrist to have your feet checked?

Yes



No



Don't know



When was the last time you went to a chiropodist or podiatrist?

.....



10. Have you had your hearing checked?

Yes



No



Don't know



When was the last time you had your hearing checked?

.....



11. Do you have epilepsy? This is an illness which means you may have fits and fall down

Yes



No



Don't know



If yes, how many fits do you have each month?



.....

If yes, who is your Epilepsy Doctor or Nurse?

.....





12. Do you have any problems going to the toilet?



	Yes	No	
	<input type="checkbox"/>		<input type="checkbox"/>

If yes:

Do you have problems having a wee or pee?
This is also called passing urine.

	Yes	No	
	<input type="checkbox"/>		<input type="checkbox"/>

Do you have problems having a poo?
This is also called passing a stool.

	Yes	No	
	<input type="checkbox"/>		<input type="checkbox"/>



13. Is there anything else you want to tell us?
This could be about aches or pain you get a lot of
the time.

.....

.....

.....

.....

.....

.....



Your Feelings

1. How are you feeling?



.....
.....
.....
.....

2. Do you have any worries?



Yes

No



If yes:

Have you spoken to anyone to get help with these worries?

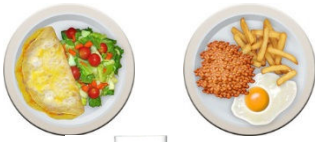


Yes

No

Don't know





Eating

1. Do you have problems eating your food?
This could be with chewing or swallowing.



Yes



No



If yes, please tell us about the problems:

.....
.....
.....
.....



2. Are there any foods you cannot eat?
Are there any foods you need to eat?
This could be because you have a particular medical problem. Some people will be ill if they eat the wrong things.

Yes



No



Don't know



If yes, please tell us about this:

.....
.....
.....
.....



How I live my life

1. Do you smoke?



Yes



No



2. Do you drink alcohol?



Yes



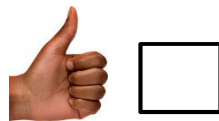
No



3. Do you want information about how to stop smoking or drinking?



Yes



No



4. Do you exercise?



Yes



No



5. Do you get the chance to exercise?



Yes



No



6. Do you have any hobbies



Yes



No



If yes, what are your hobbies?

.....
.....
.....
.....



7. Do you have a job?



Yes



No



If no, do you want a job?

Yes



No



8. Are you a volunteer?

This means working but not getting money for it.



Yes



No





9. Do you live in a house or flat on your own?

Yes

No



If no, who else do you live with?

.....
.....
.....
.....

10. Are you getting support to do the things you want to do?

Yes

No

Don't know



You need to bring these things with you to your Health Check:



1. A jar with your wee or pee in it.
This is called a urine sample.

2. Your tablets or medicines, if you have any.

Please list the names of your tablets and medicines here:



.....

.....

.....

.....

.....

.....

.....








3. Your Health Action Plan if you have one.



4. Your Hospital or Patient Passport if you have one.

Medicines Reminder Chart

- You can fill in this chart with the names of the tablets or medicines you need to take each day.
- You can write down when you should take them and how much you need.
- This will help you to remember to take your tablets and medicines.

				
Medicines or tablets	Breakfast	Midday	Evening meal	Bedtime