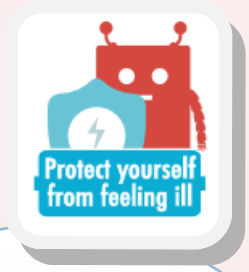
Stay SUPERCHARGED and fully fit by having your Annual Health Check

For anyone with a Learning Disability aged 14+

NHS
Gloucestershire
Clinical Commissioning Group



Step 1: COVID –19 may mean that you have a remote / virtual Annual Health Check.

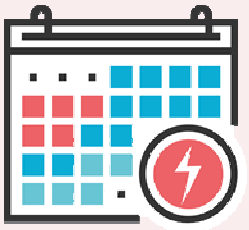
Step 2: It is important you complete this questionnaire and send it back to your GP surgery. This will help your Doctor to arrange a face to face or remote Annual Health Check.

My name is

I like to be called

My date of birth is

The date of my Health Check is



My preferred communication method to help me understand:-

- ☐ Speaking
- ☐ Signing
- ☐ Pictures
- ☐ Using a communication aid
- ☐ Easy Read
- ☐ Using gestures or pointing

This is the name of the person who looks after me:-

Family Carer

Paid Carer

Where do you currently live?

- ○ With family or friends
- ○ In a residential care home
- ◉ Other
- ○ In my own house / flat
- ○ In supported living

Do you have a job? ✓ ◉ Yes × ○ No

If yes, what is your job?

Any known health problems?

- ☐ Epilepsy
- ☐ Heart problem
- ☐ Diabetes
- ☐ Lung / breathing problem

Do you have any allergies?

Can you easily **tell** people if you are ill or in pain? ✓ ◉ Yes × ○ No

If you answered no—how would someone know if you were ill or in pain? (e.g. facial expressions, pictures, noises)

If known, what are your **normal observations**?

Blood Pressure

Pulse

Temperature

Breathing Rate

What is your current weight?

Has your weight changed? ✓ ○ Yes × ◉ No

How tall are you?

Are you able to **move around** easily? ✓ ◯ Yes × ◉ No

Do you use mobility aids? (e.g. a wheelchair, stick, frame)

Has your **mobility** changed in the last year?

◯ It's worse ◯ It's the same ◯ It's better

What **exercise** do you do?

Do you drink **alcohol**? ✓ ◯ Yes × ◉ No

Do you **smoke**? ✓ ◯ Yes × ◉ No

Do you go to the **dentist**? ✓ ◯ Yes × ◯ No

When was your last appointment?

Do you go to the **optician**? ✓ ◯ Yes × ◉ No

When was your last appointment? -

Have you had your **feet** checked? ✓ ◯ Yes × ◉ No

When was your last appointment?

Have you had your **hearing** checked? ✓ ◯ Yes × ◉ No

When was your last appointment?

Do you find it hard to **bend**? ✓ ◯ Yes × ◉ No

Do you find it hard to **hold things**? ✓ ◯ Yes × ◉ No

Do you find it hard to **walk**? ✓ ◯ Yes × ◉ No

Do you have any problems with eating and drinking? ✓ ◯ Yes × ◉ No

Do you see a dietician? ✓ ◯ Yes × ◉ No

Do you have any heartburn or indigestion? ✓ ◯ Yes × ◉ No

Can you choose what your **eat**? ✓ ◯ Yes × ◉ No

What food do you eat?

Has your appetite changed recently? ✓ ◯ Yes × ◉ No

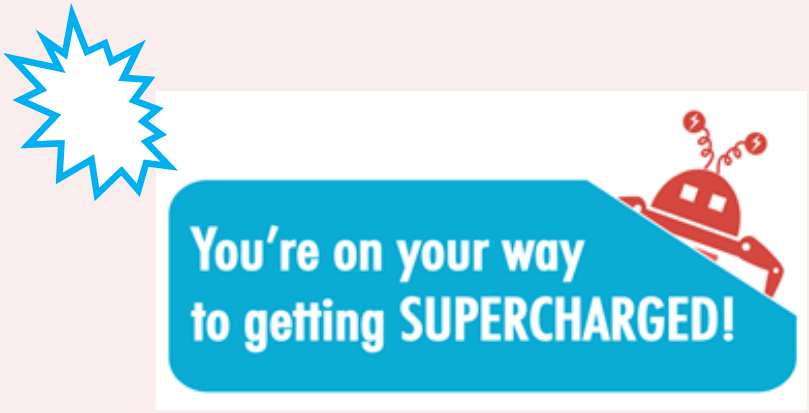
Do you have problems with chewing or swallowing? ✓ ◯ Yes × ◉ No

If you have **diabetes**, please answer the following questions**:-**

Who is your diabetes doctor or nurse?

When was your last appointment?

Is there anything you want to tell me about your diabetes?



If you have **epilepsy**, please answer the following questions:-

Who is your epilepsy doctor or nurse?

When was your last appointment?

How many seizures do you have a month?

Is there anything you want to tell me about your epilepsy?

Have there been any **big changes** in your life? (e.g. moving house, a death) ✓ ◯ Yes × ◉ No

Do you **self-harm**? ✓ ◯ Yes × ◉ No

Have there been any other changes to your **mental health**?

Do you have any **worries**? ✓ ◯ Yes × ◉ No

Do you think you have **forgotten** more things? ✓ ◯ Yes × ◉ No

Have you started to have **mood swings**? ✓ ◯ Yes × ◉ No

Do you have any problems **sleeping**? ✓ ◯ Yes × ◉ No

Do you take any tablets or medicines other than those prescribed by your doctor? ✓ ◯ Yes × ◉ No

If yes, are they vitamins, painkillers, laxatives or something else?

Are you in a relationship? ✓ ◯ Yes × ◉ No

Do you use contraception? ✓ ◯ Yes × ◉ No

Have you had a sexual health check? ✓ ◯ Yes × ◉ No

Do you have problems going to the toilet? ✓ ◯ Yes × ◉ No

If **yes**, do you have problems going for a wee? ✓ ◯ Yes × ◉ No

Do you have problems going for a poo? ✓ ◯ Yes × ◯ No

Are you between 60 and 74 years old? ✓ ◯ Yes × ◉ No

If **yes**, have you been offered bowel screening? ✓ ◯ Yes × ◉ No

For Women

Have you had breast screening? ✓ ◯ Yes × ◉ No

Have you had cervical screening (smear test)? ✓ ◯ Yes × ◉ No

Have there been changes in your menstrual cycle (period)? ✓ ◯ Yes × ◉ No

For Men

Have you had your testicles (balls) checked? ✓ ◯ Yes × ◉ No

Are you between 65 and 74 years old? ✓ ◯ Yes × ◉ No

Have you had AAA screening (Abdominal Aortic Aneurysm) to check if there is a bulge or swelling in the main blood vessel that runs from your heart down through your tummy)? ✓ ◯ Yes × ◉ No

Have you noticed any unusual bruises or sores? ✓ ◯ Yes × ◉ No

Have you noticed changes in any moles? ✓ ◯ Yes × ◉ No

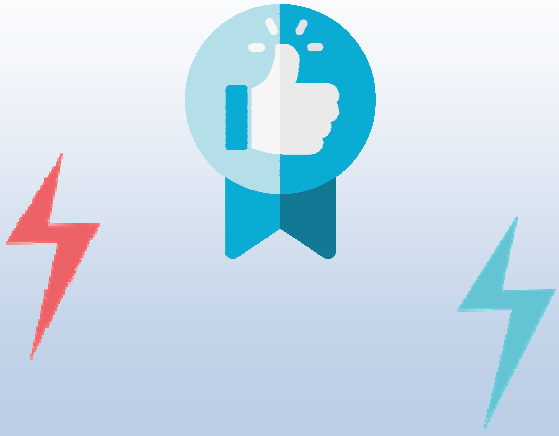
Have you had a flu jab in the last 12 months? ✓ ◯ Yes × ◉ No

Have you ever had a jab for pneumonia and bronchitis? ✓ ◯ Yes × ◉ No

Do you have a fear of jabs? ✓ ◯ Yes × ◉ No

At your Annual Health Check your Doctor or Nurse will check your:-

- ☐ Weight
- ☐ Heart Rate
- ☐ Blood Pressure
- ☐ Blood Sample
- ☐ Urine Sample



Do you have any medical fears / phobias your Doctor or Nurse should know about:- ✓ ◯ Yes × ◉ No

If you answered yes, tell us how the Doctor or Nurse can help you to be less anxious about your Annual Health Check?

At the end of your Annual Health Check appointment, your Doctor or Nurse may issue a Health Check Action Plan. Keep it safe and follow the advice.

You can use this page if you have any questions you would like to ask the Doctor or Nurse at your Annual Health Check appointment.

Produced by the Learning Disability Health Facilitation Team in partnership with Kingfisher Treasure Seekers.

Printed copies of the Pre-Health Check Questionnaire can be obtained from the Health Facilitation Team on Tel. No. 01452 321015 or by email to Simon.Shorrick@ghc.nhs.uk.

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