
















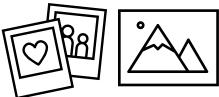




















Annual Health Check








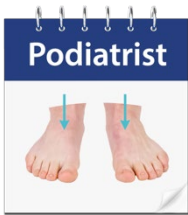


Pre-check questionnaire









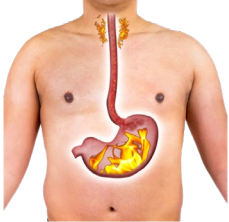
	<p>My name is.....</p> <p>I like to be called.....</p> <p>My date of birth.....</p> <p>My phone number.....</p>		
	<p>Please tick yes or no for each question</p>	 yes	 no
	<p>Is it okay to share information about you with other health professionals?</p>	<input type="checkbox"/>	<input type="checkbox"/>
	<p>Did anyone help you with this form?</p>	<input type="checkbox"/>	<input type="checkbox"/>
	<p>Your first language.....</p>		
	<p>Do you have any communication difficulties?</p>	<input type="checkbox"/>	<input type="checkbox"/>










	Please tick all that apply I communicate by...	
	talking	<input type="checkbox"/>
	signing	<input type="checkbox"/>
	using a communication aid	<input type="checkbox"/>
	pointing	<input type="checkbox"/>
	using gestures	<input type="checkbox"/>
	other – please give details below	<input type="checkbox"/>
	
	I can understand information if it is...	
	written words	<input type="checkbox"/>
	with pictures	<input type="checkbox"/>
	spoken	<input type="checkbox"/>
	interpreted by a carer	<input type="checkbox"/>
	other – please give details below	<input type="checkbox"/>
	







	<p>My next of kin is.....</p> <p>My main carer is.....</p> <p>I live with.....</p>		
	<p>Please tick yes or no for each question</p>	 yes	 no
	<p>Do you see anyone from CLDS, or another learning disabilities service?</p>	<input type="checkbox"/>	<input type="checkbox"/>
	<p>Do you have a health action plan?</p>	<input type="checkbox"/>	<input type="checkbox"/>
	<p>Do you have a hospital passport?</p>	<input type="checkbox"/>	<input type="checkbox"/>
	<p>If you do have a health action plan or a hospital passport, please bring these to your annual health check appointment</p>		
	<p>Do you have any allergies?</p>	<input type="checkbox"/>	<input type="checkbox"/>
	<p>If you ticked yes, please list your allergies here</p> <p>.....</p> <p>.....</p> <p>.....</p>		

	Please tick yes or no for each question	 yes	 no
	Do you have any problems taking your medication?	<input type="checkbox"/>	<input type="checkbox"/>
	Do you take any over-the-counter medication?	<input type="checkbox"/>	<input type="checkbox"/>
	Do you have any medical fears or phobias, e.g. blood tests, blood pressure tests, injections?	<input type="checkbox"/>	<input type="checkbox"/>
	Do you have any problems with your teeth or mouth?	<input type="checkbox"/>	<input type="checkbox"/>
	When did you last see a dentist?		
	Do you have any problems with your vision?	<input type="checkbox"/>	<input type="checkbox"/>
	When did you last see an optician?		

	Please tick yes or no for each question	 yes	 no
	Do you have any hearing difficulty?	<input type="checkbox"/>	<input type="checkbox"/>
	Do you wear a hearing aid?	<input type="checkbox"/>	<input type="checkbox"/>
	Have you had your hearing checked?	<input type="checkbox"/>	<input type="checkbox"/>
	Do you have any problems with your feet?	<input type="checkbox"/>	<input type="checkbox"/>
	Do you see a podiatrist?	<input type="checkbox"/>	<input type="checkbox"/>
	Do you have any problems with your mobility?	<input type="checkbox"/>	<input type="checkbox"/>
	Do you use any mobility aids, like a wheelchair, walking frame or stick?	<input type="checkbox"/>	<input type="checkbox"/>

	Please tick yes or no for each question	 yes	 no
	Do you see a physiotherapist or occupational therapist (OT)?	<input type="checkbox"/>	<input type="checkbox"/>
	Do you have any problems with eating and drinking?	<input type="checkbox"/>	<input type="checkbox"/>
	Do you see a dietician?	<input type="checkbox"/>	<input type="checkbox"/>
	Do you have any problems with swallowing?	<input type="checkbox"/>	<input type="checkbox"/>
	Do you see a speech and language therapist?	<input type="checkbox"/>	<input type="checkbox"/>
	Do you have any heartburn or indigestion?	<input type="checkbox"/>	<input type="checkbox"/>

	Please tick yes or no for each question	 yes	 no
	Do you have any problems going for a poo, e.g. constipation, diarrhoea or incontinence?	<input type="checkbox"/>	<input type="checkbox"/>
	Do you have any problems going for a wee, e.g. pain, blood or incontinence?	<input type="checkbox"/>	<input type="checkbox"/>
	Do you have epilepsy?	<input type="checkbox"/>	<input type="checkbox"/>
	If you ticked yes , how many seizures have you had in the past month?		
For men and women aged 50 to 74			
	Have you been sent a kit to test for bowel cancer?	<input type="checkbox"/>	<input type="checkbox"/>
	When did you last do the test?		

	Please tick yes or no for each question	 yes	 no
For men and women aged 55 to 74 (who smoke or have smoked)			
	Have you had lung cancer screening?	<input type="checkbox"/>	<input type="checkbox"/>
	When was your phone questionnaire?		
	If invited, when was your CT scan?		

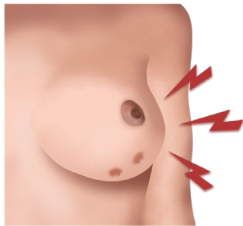
For men



Have you had any pain or swelling in your testicles?

☐
☐

For women



Have you noticed any pain or lumps in your breasts?

☐
☐


If you are **over 50**, when did you last go for breast screening?

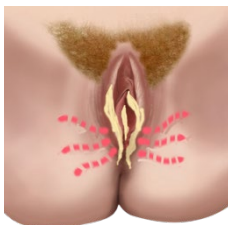
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Do you have regular periods?








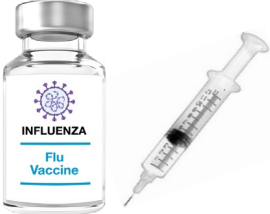

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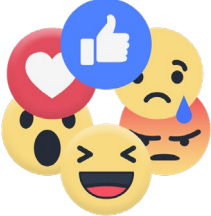


Any problems with your periods, e.g. are they heavy, painful or irregular?

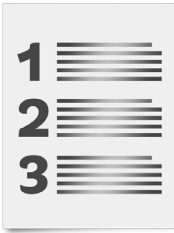
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Do you have any vaginal discharge that is smelly or makes you sore?

☐
☐

		 yes	 no
For women aged 25 to 64			
	Have you had a cervical smear test?	<input type="checkbox"/>	<input type="checkbox"/>
	When was your last smear test?		
For everyone			
	Would you like advice about safe sex and contraception?	<input type="checkbox"/>	<input type="checkbox"/>
	Would you like advice about healthy eating?	<input type="checkbox"/>	<input type="checkbox"/>
	When did you last have a flu jab?		
	Do you drink alcohol?	<input type="checkbox"/>	<input type="checkbox"/>

		 yes	 no
	<p>How much alcohol do you drink?</p> <p>.....</p>		
	<p>Do you take any recreational drugs?</p>	<input type="checkbox"/>	<input type="checkbox"/>
	<p>Do you smoke?</p>	<input type="checkbox"/>	<input type="checkbox"/>
	<p>If you ticked yes, how much do you smoke?</p> <p>.....</p>		
	<p>How are you feeling?</p> <p>.....</p>		
	<p>Is there anything that you're worried about?</p> <p>.....</p> <p>.....</p> <p>.....</p>		



Please use this space to tell us anything else you'd like us to know

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