Resource 2

easy read

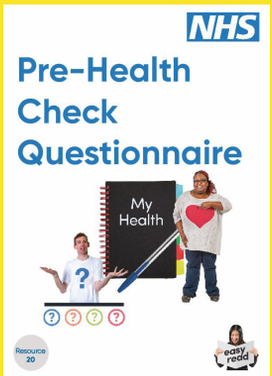
NHS

Pre-Health Check Questionnaire

Print version

Accessible Information

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

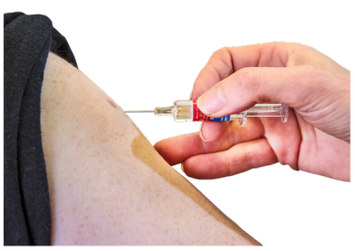
○ **Male** ○ **Female** ○ **Other** (please write in box below)

Address

About me

Am I on your GP's LD Register?

○ Yes ○ No ○ I don't know



Do you get a flu jab?

○ Yes ○ No ○ I don't know

If yes, what was the date of your last flu jab?

DAY	MONTH	YEAR

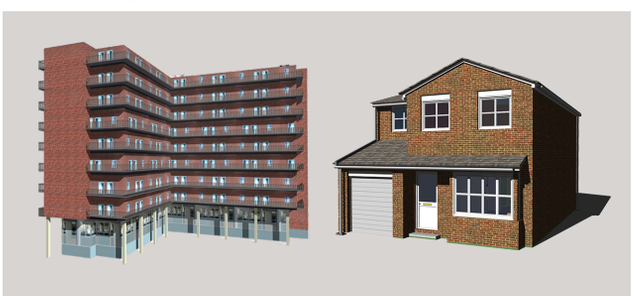
Where I live

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?**

Things That Help Me

3.a. **What helps you attend a GP appointment?**
This can be any reasonable adjustments

3.b. **Do you have any medical fears/phobias?**

Yes ○ **No** ○

3.c. **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

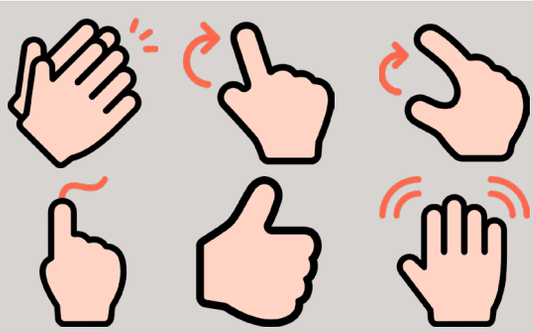
6. **The language I speak and understand is:**

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

○ **Talking**

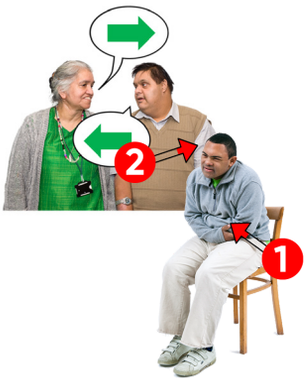
○ **Signing**

○ **Using a communication aid**



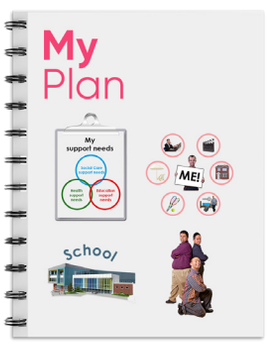
○ **Pointing and gestures**

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** ○

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?**

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 dietician?**

Yes ○ No ○

Weight & appetite

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

22.a. **Are you prescribed any medication from your doctor?**

Yes ○ No ○

22.a. **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

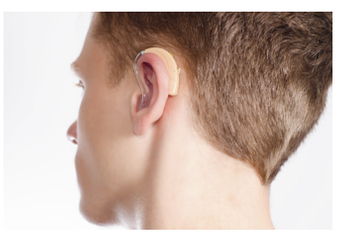
My hearing

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 ○

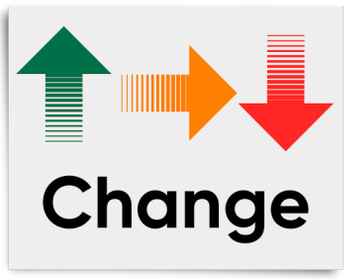
35. **Any comments about your mobility**

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

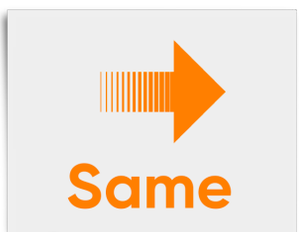
Yes ○ No ○

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 ○

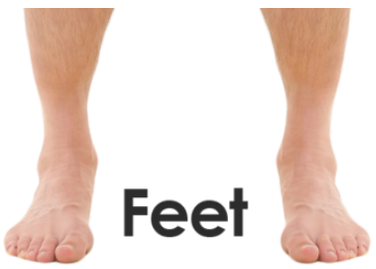
38. **Do you see a physiotherapist** (physiotherapists work with people to help with a range of problems which affect your movement)?

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 ○

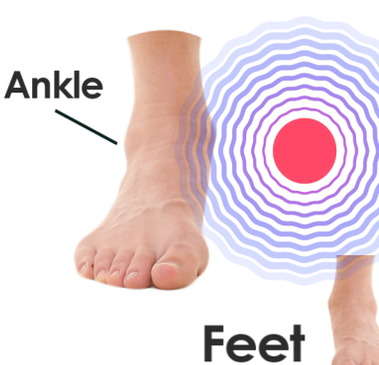
My feet



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

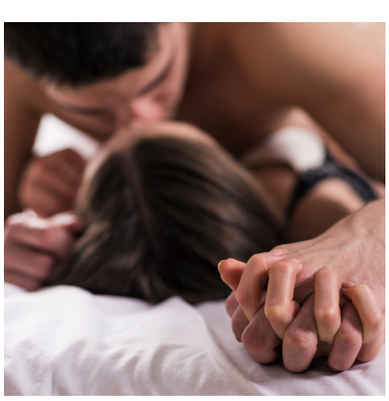
Hair, skin and nails

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)?

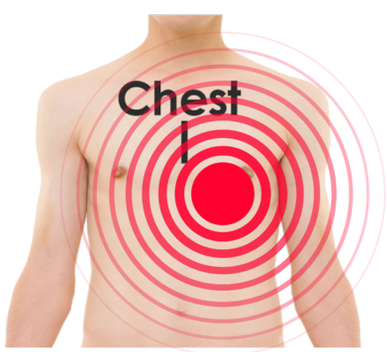
Yes ○ **No** ○

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?**

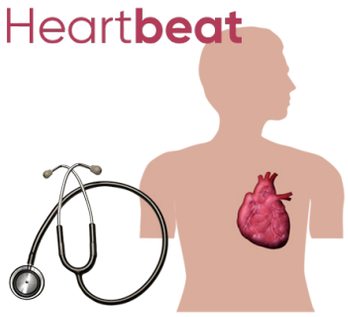


53.a. **Do you get any pain in your chest?**

Yes ○ No ○

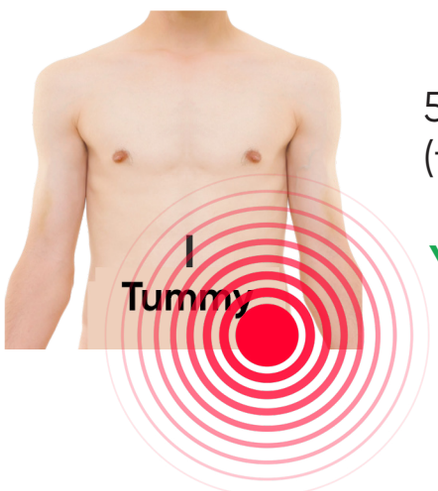
53.b. **If yes, when does the pain happen?**

Pains



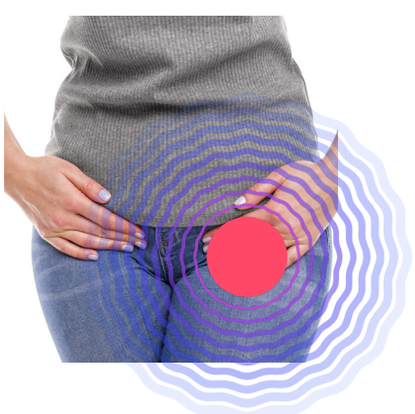
54. **Do you feel you have an uneven heart beat or your heart beats fast?**

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 ○

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

Yes ○ No ○

Poo

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

Yes ○ No ○

Wee

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

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)?

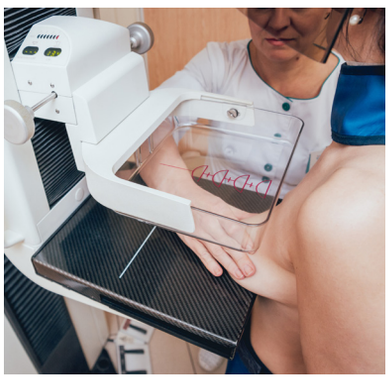
Yes ○ No ○

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 ○

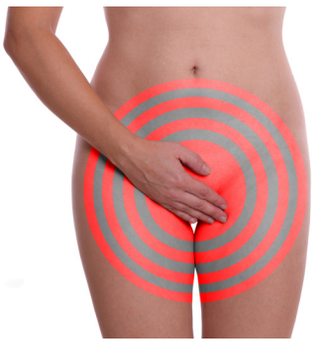
78. **Is the bleeding very heavy?**

Yes ○ No ○

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

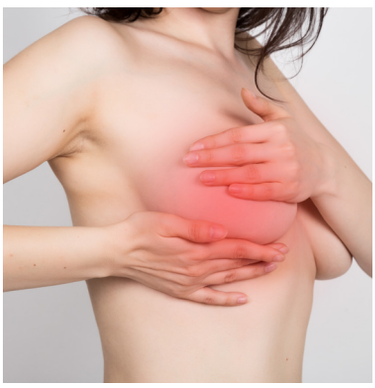
Yes ○ No ○

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** ○

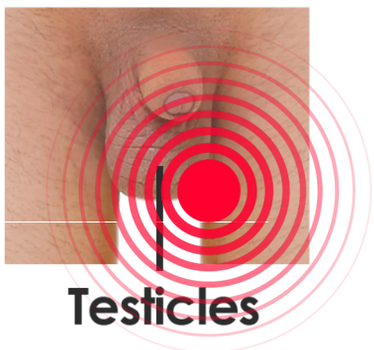
Men and Women aged 60-69

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

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

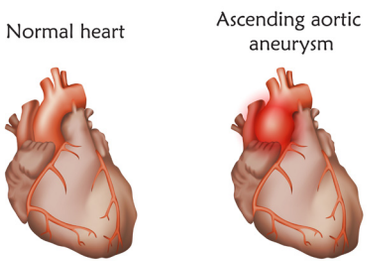
DAY MONTH YEAR

For Men



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

Yes ○ No ○



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

Yes ○ No ○

My care and support

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

Family

Name of family carer

My care and support

Family

Family carer's contact number

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

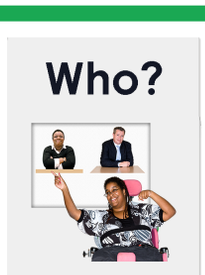
Social worker's contact number

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 ○



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

Notes

Notes

Notes

Primary Care Accessible Resources

Resource 2: Pre-Health Check Questionnaire

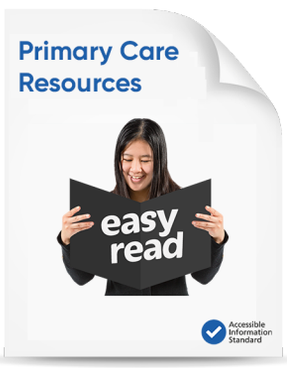
Suffolk Learning Disability Partnership

Made in co-production

This booklet was co-produced by Ace Anglia.

NHS

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



This booklet is Resource 2 and forms part of a number of projects that help to explain things about primary care services.

Accessible Information

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info@aceanglia.com

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