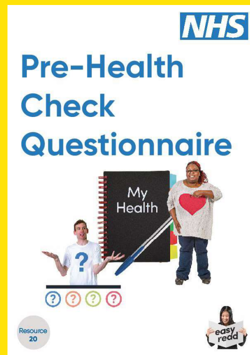
Pre-Health Check Questionnaire

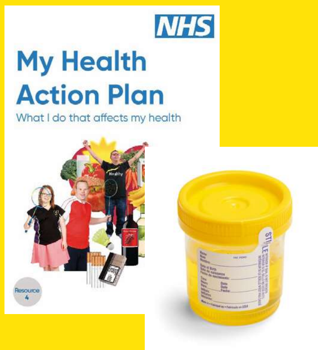
About this booklet



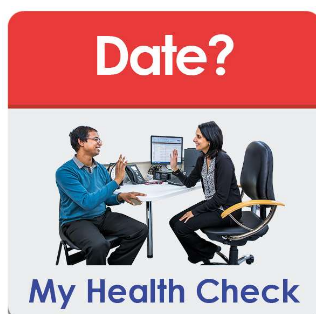
Please fill in this booklet before you come to your Annual Health Check. You may want to ask for help from family, a friend or a support worker.

It is OK if you cannot fill this form in before your Annual Health Check.

Please bring a list of your medications 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 Health Check?

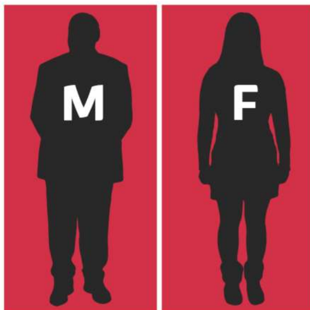
DAY	MONTH	YEAR

About me

Name

Date of birth

DAY MONTH YEAR



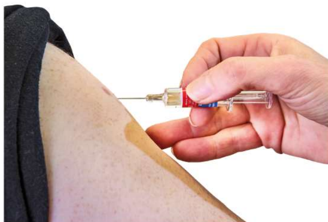
○ **Male** ○ **Female** ○ **Other** (please write in box below)

Address

About me

Am I on your GP's LD Register?

○ Yes ○ No ○ I don't know



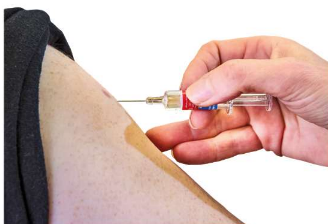
Do you get a flu jab?

○ Yes ○ No ○ I don't know

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

DAY	MONTH	YEAR

What other jabs have you had?
Eg, Covid, meningitis



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?**

Learning and Training

3.a. **Are you doing Learning or Training?**

Yes ○ No ○

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

Things That Help Me

4.a. **What makes it easier for you when you go to the GP?** This can be any reasonable adjustments

4.b. **Is there anything that you are scared about when you go to the Doctors?**

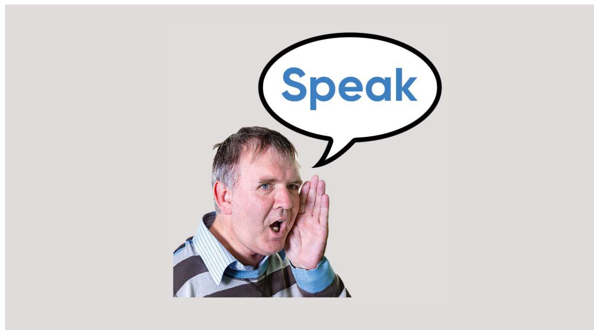
Yes ○ **No** ○

4.c. **If yes, what?**

My Communication

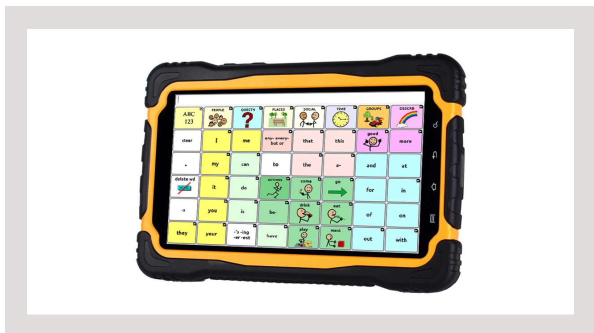
5. **The language I speak and understand is:**

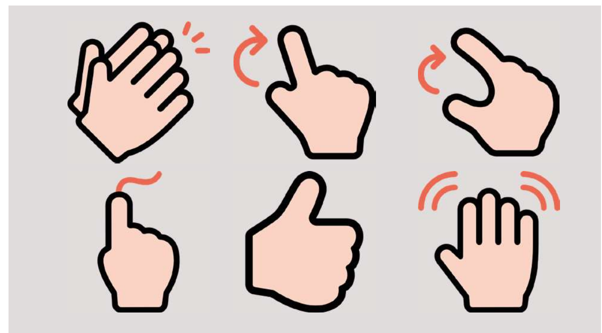
6. **How do you get your message across?**
(tick as many as you like)



Talking

Signing





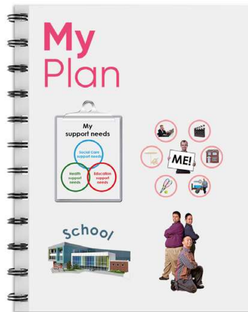
Using a communication aid

Pointing and gestures

My Communication

7a. **Can you tell people if you are in pain?**

Yes ◯ No ◯



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

Yes ◯ No ◯

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

Yes ◯ No ◯

My Communication

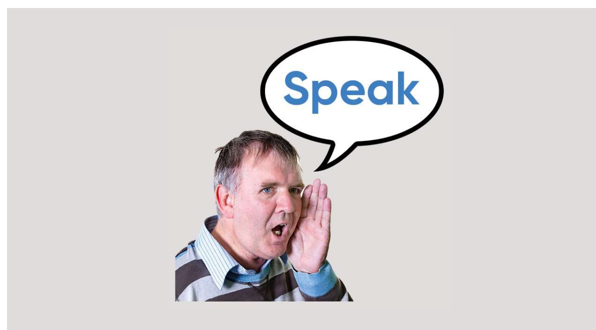
9.a. **Do you have any difficulty in communicating?**

Yes ◯ **No** ◯

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

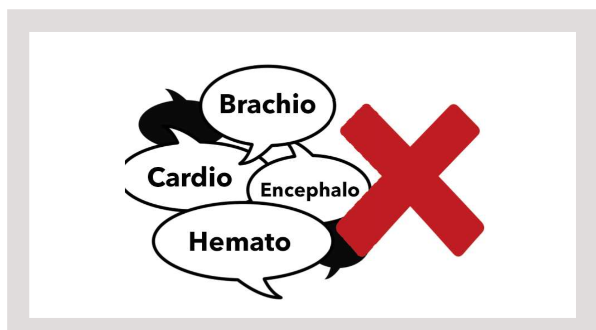
My Communication

10. **What helps you to understand others?**



○ **Talking slowly**

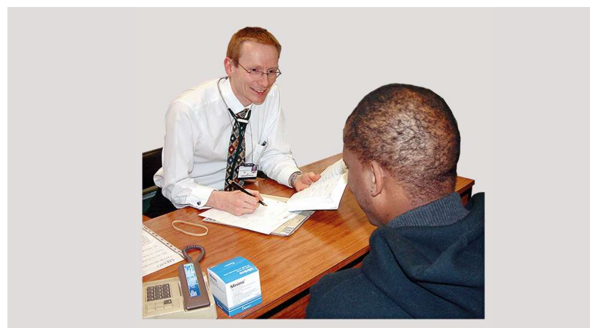
○ **Signing**



○ **Talking without jargon**

○ **Explaining with pictures**

○ **Writing things down**



○ **Taking more time when explaining**

My hearing

11. **Do you have any difficulty hearing?**

Yes ◯ No ◯

12.a. **Do you have a hearing aid?**

Yes ◯ No ◯

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

Yes ◯ No ◯

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

Yes ◯ No ◯

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

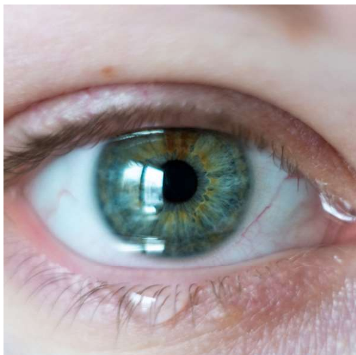
DAY	MONTH	YEAR

My diet

14. **What foods and drink do you like?**

15.a. **Do you cough when you eat?**

Yes ○ **No** ○

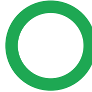
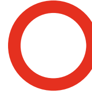


15.b. **Do your eyes water when you are eating?**

Yes ○ **No** ○

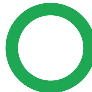
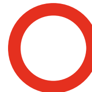
My diet

16. **Do you have any difficulties eating, drinking or swallowing?**

Yes  No 

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

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

Yes  No 

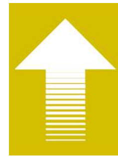
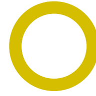
17. **Do you have any burning pain in your chest?** (heartburn or indigestion)

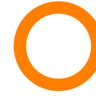
Yes No

My diet

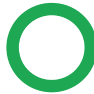
18. **What do you eat in a day?**

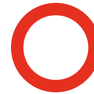
19. **Are you eating more or less than you used to?**

 More 

Less 

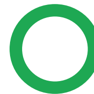
20. **Do you see a dietician?**

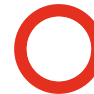
Yes 

No 

Weight & appetite

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

Yes 

No 

Exercise

22. **What exercise do you do?**

Alcohol

22.a. **Do you drink alcohol?**

Yes ◯ No ◯

22.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

23. **Do you want help to drink less alcohol?**

Yes ◯ No ◯

Smoking

24.a. **Do you smoke?**

Yes ○ **No** ○

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

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

Yes ○ **No** ○

My breathing

26. **Do you have any problems with your breathing?**

Yes ◯ No ◯

27.a. **Do you cough?**

Yes ◯ No ◯

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

Yes ◯ No ◯

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

Tablets and medicines

28. **Are you prescribed any medication from your doctor?**

Yes ◯ No ◯

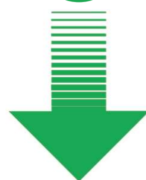
29. **Do you take any tablets or medicines that are not from your doctor** (things like vitamins, painkillers, laxatives)?

Yes ◯ No ◯

My allergies

30.a. **Do you have any allergies?**

Yes ◯ No ◯



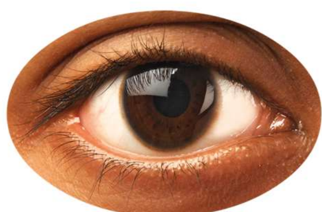
30.b. **If yes, what are you allergic to?**

Memory

31. **Do you or your carer think there has been a change in your memory?** For example, do you forget things more than you used to?

Yes ○ No ○

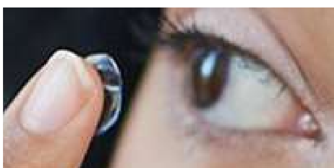
My eyesight



My vision

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

Yes ○ No ○



33. **Do you wear glasses or contact lenses?**

Yes ○ No ○

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

DAY	MONTH	YEAR

My teeth

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

Yes ◯ No ◯

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

36. **'Do you have dentures/ false teeth?**

Yes ◯ No ◯

37. **Which dentist do you go to?**

38. **Do you go to the dentist regularly?**

Yes ◯ No ◯

39. **What was the date of your last dental appointment?**

DAY MONTH YEAR

FOR GP REFERENCE: ROUTINE CARE

My mobility

40. **Are you able to move around easily?**

Yes ◯ No ◯

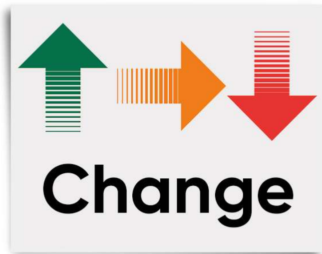
41. **Any comments about your mobility**

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

Yes ◯ No ◯

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

My mobility



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

It's better ○ It's the same ○ It's worse ○

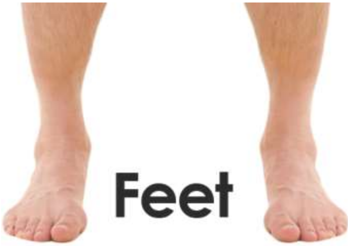
44. **Do you see a physiotherapist** (physiotherapists work with people to help with a range of problems which affect your movement)?

Yes ○ No ○

45. **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 ○

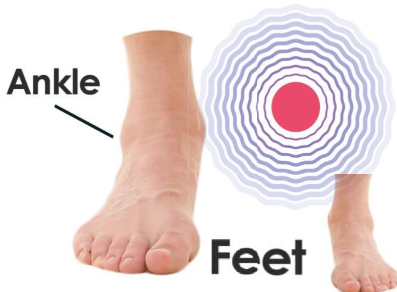
My feet



46.a. **Do you have any problems with your feet?**

Yes ○ No ○

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



47. **Do you have swelling of your ankles or feet?**

Yes ○ No ○

48a. **Do you visit the podiatrist or chiropodist** (someone who can help with common foot problems)?

Yes ○ No ○

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

DAY MONTH YEAR

49. **Who cuts your toe nails?**

Hair, skin and nails

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

Yes ◯ No ◯

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

Sex

51. **Do you have sex?**

Yes ◯ No ◯

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

Yes ◯ No ◯

53. **Have you had sexual health screening?**

Yes ◯ No ◯

My sleep

54. **Do you have problems sleeping?**

Yes ○ No ○

55. **What time do you go to bed?**

56. **What time do you wake up?**

57. **Does anyone tell you, you snore?**

Yes ○ No ○

Epilepsy

58.a. **Do you have epilepsy?**

Yes ○ **No** ○

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

Specialists

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

Yes ○ **No** ○

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

Yes ○ **No** ○

Epilepsy

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

Yes ◯ No ◯

Drugs

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

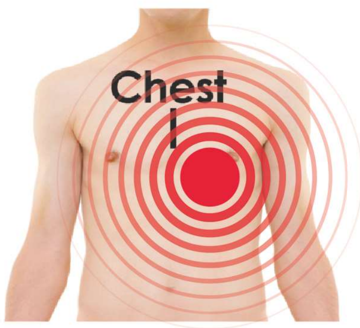
Yes ◯ No ◯

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

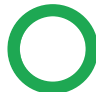
Yes ◯ No ◯

Pains

63. **How would someone know you are in pain?**



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

Yes 

No

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

Pains

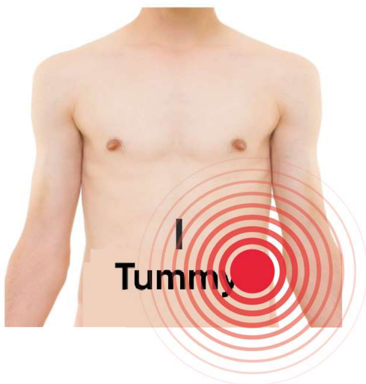
65. **Do you have pain?**

Yes ◯ No ◯

53.b. **If yes, where is the pain? When does the pain happen?**

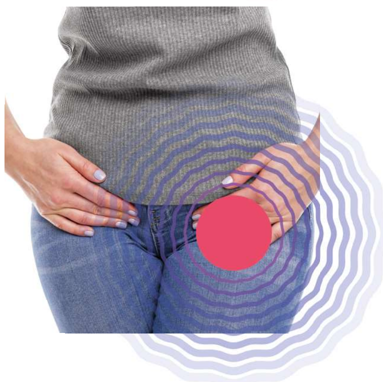
66. **Do you feel you have an uneven heart beat or your heart beats fast?**

Yes ◯ No ◯



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

Yes ◯ No ◯



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

Yes ◯ No ◯

Continence

69. **How many times a day do you have a poo?**

70. **What does your poo look like?**

○ **Type 1: Serve constipation**
Seperate, hard lumps

○ **Type 2: Mild constipation**
Lumpy and sausage like

○ **Type 3: Normal**
A sausage-shape with cracks in the surface

○ **Type 4: Normal**
Like a smooth, soft sausage or snake

○ **Type 5: Lacking fiber**
Soft blobs with clear-cut edges

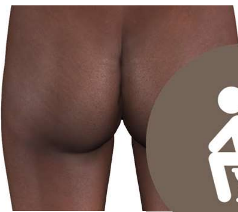
○ **Type 6: Mild diarrhea**
Mushy consistency with ragged edges

○ **Type 7: Serve diarrhea**
Liquid consistency with no solid pieces

Continence

71. **Do you have any constipation or diarrhoea?**

Yes ◯ No ◯



Poo

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

Yes ◯ No ◯

73. **Does it hurt when you poo?**

Yes ◯ No ◯

Wee

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

Yes ◯ No ◯

75. **Does it hurt when you wee?**

Yes ◯ No ◯

Continence

76. **Is there any blood in your wee?**

Yes ◯ No ◯

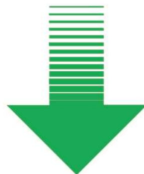
77. **Do you have any other problems when you wee** (things like going to toilet the a lot)?

78. **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 ◯

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

Yes ◯ No ◯



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

Any other health conditions

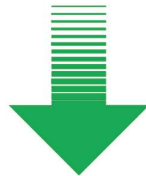
80. **Do you have any other health conditions** (If you don't, leave the box blank)?

My Family

Family

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

Yes ○ No ○ I don't know ○



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

My Mental Health

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

Yes ◯ No ◯

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

Yes ◯ No ◯

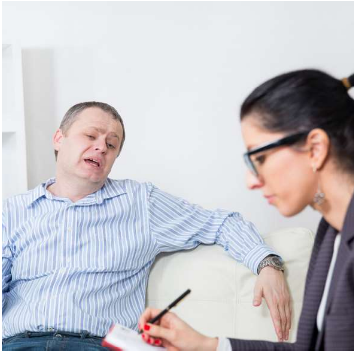
84. **Do you get angry and shout at people a lot?**

Yes ◯ No ◯

85. **Do you ever try to hurt yourself?**

Yes ◯ No ◯

My Mental Health



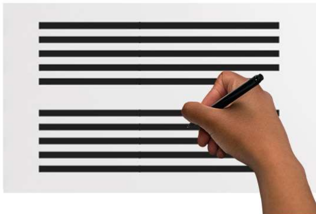
86. **Do you see a psychiatrist** (this is someone who specialises in the prevention, diagnosis, and treatment of mental illness)?

Yes ◯ No ◯

87. **Do you have support from the mental health team or Learning Disability team?**

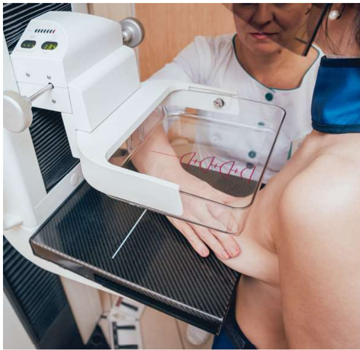
Yes ◯ No ◯

Please write in box



88. **If you answered yes to any of the questions, please write more information in the textbox.**

For Women



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

Yes ○ **No** ○

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

DAY	MONTH	YEAR

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

Yes ○ **No** ○

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

DAY	MONTH	YEAR

For Women

91. **Do you have periods?**

Yes ◯ No ◯

92. **Are your periods painful?**

Yes ◯ No ◯

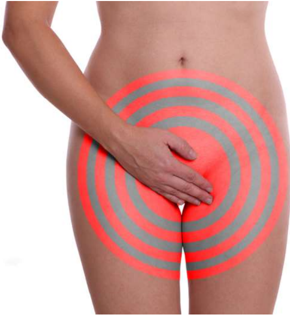
93. **Is the bleeding very heavy?**

Yes ◯ No ◯

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

Yes ◯ No ◯

For Women



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

Yes ○ No ○

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

Yes ○ No ○

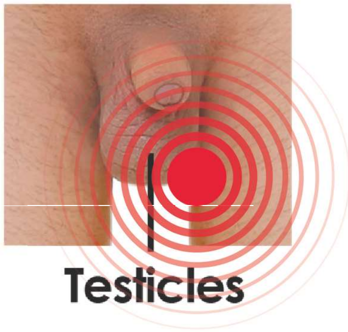
Men and Women aged 60-69

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

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

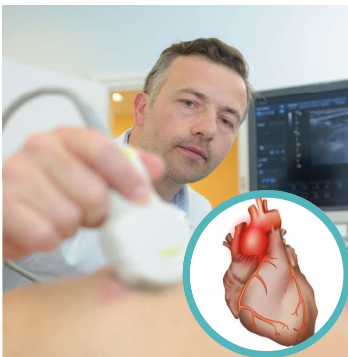
DAY	MONTH	YEAR

For Men



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

Yes ◯ No ◯



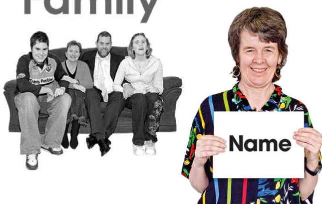
99. **If you are 65 or over, have you have been for an Ascending Aortic Aneurism screening?**

Yes ◯ No ◯

My care and support

100. **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

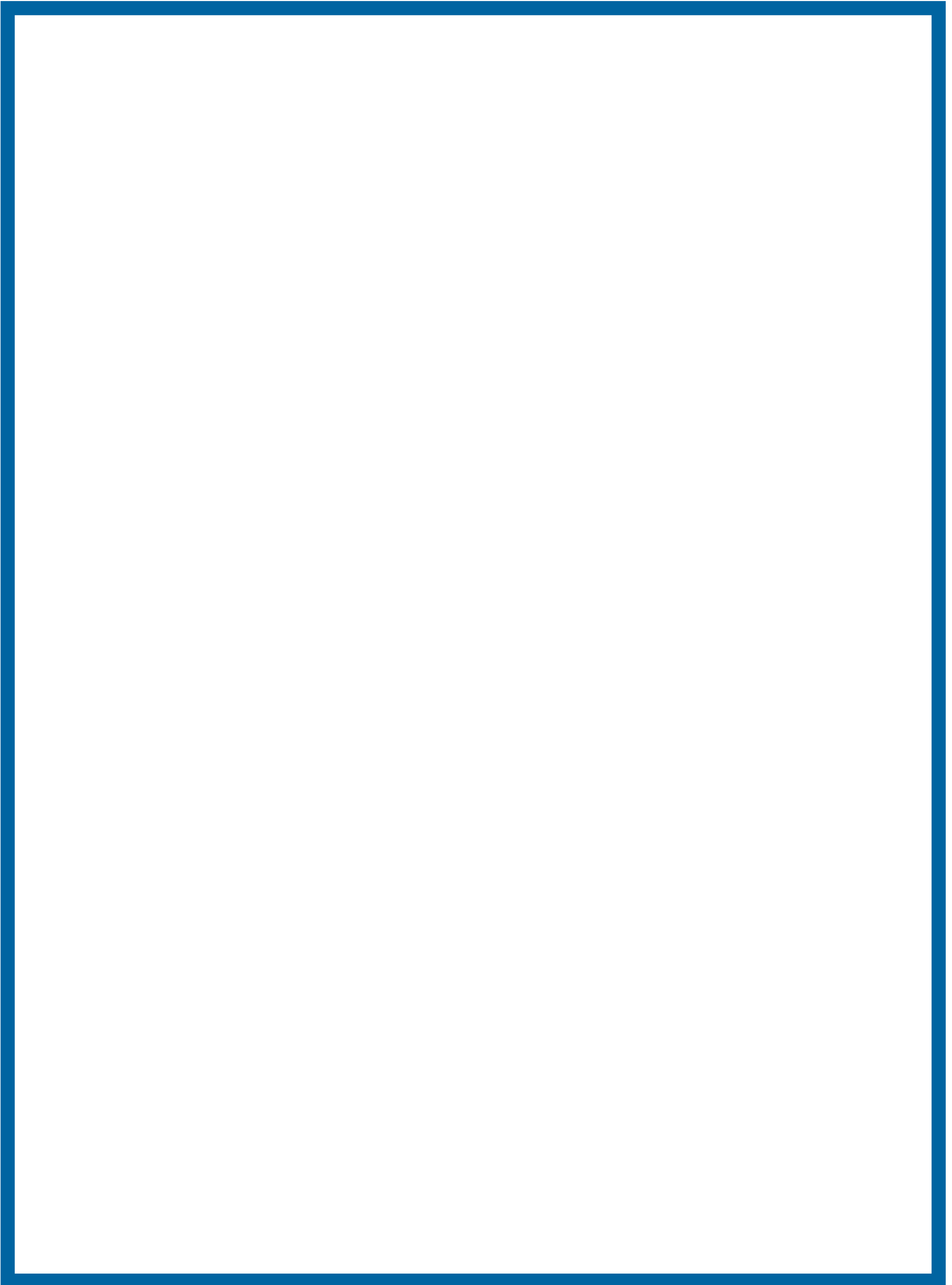
101.a. **Are you a carer for anyone** (this could be for children, parents or a partner)?

Yes

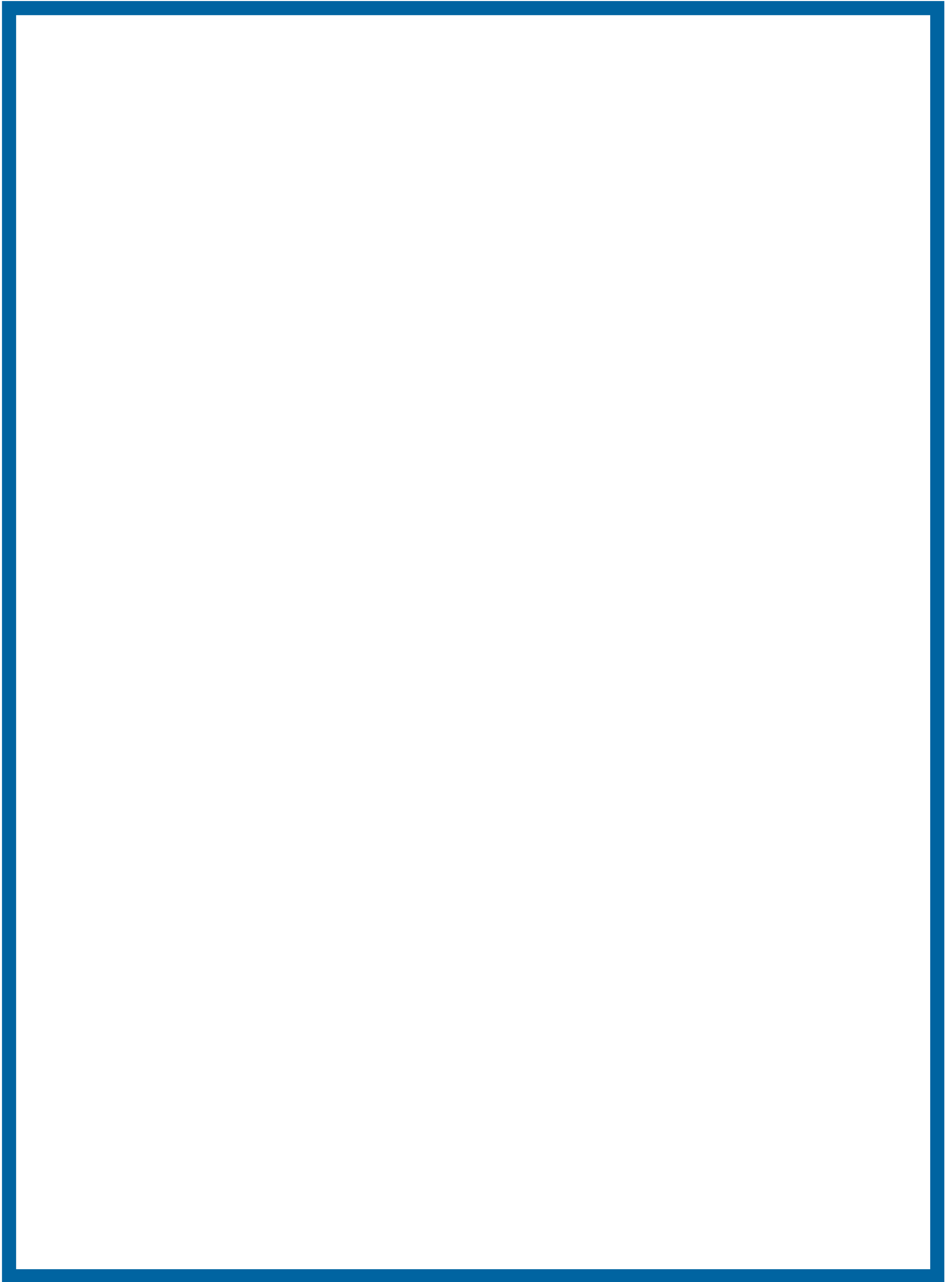
No

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

Notes



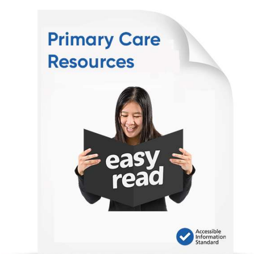
Notes



Primary Care Accessible Resources
Resource 2: Pre-Health Check Questionnaire

This booklet was made in co-production by members of the Suffolk Learning Disability Partnership.

The resources were originally funded by Clinical Commissioning Groups in Suffolk. They have been amended for use across Birmingham & Solihull 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.

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

For more information, please e-mail:
info@aceanglia.com

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