

# My Health Check

## PRE-ASSESSMENT QUESTIONNAIRE



We would like to invite you to your Annual Health Check

**Step 1.** Please fill in this questionnaire and return it to your GP Practice **BEFORE** your health check





If you need help to fill in your questionnaire you may like to ask a family member, a friend, your carer or support worker

You may like to think about some of your answers before writing them down – you may like to complete the questionnaire over several days







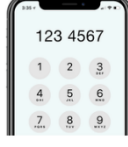

**Step 2.** Your GP Practice will look at your completed questionnaire, then tell you the **DATE** of your health check


### MY ANNUAL HEALTH CHECK



	<b>Date</b>		
	<b>Time</b>		



## About Me

	My name	
	Date of birth	
	Gender	
	Ethnicity	
	My address	
	Home Telephone No.	
	Mobile Telephone No.	
	Email Address	

	<p>How I like people to contact me</p>	<p> <input type="checkbox"/> Telephone – Home   <input type="checkbox"/> or Mobile   <input type="checkbox"/>  <input type="checkbox"/> Telephone – Text   <input type="checkbox"/>  <input type="checkbox"/> Email   <input type="checkbox"/>   <input type="checkbox"/> Easy Read letter  <input type="checkbox"/> My carer   <input type="checkbox"/> </p>
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## Review

### Changes we can make to help you are called Reasonable Adjustments



	<p>What changes can your GP Practice make to help you attend your health check?</p>	<p> <input type="checkbox"/> Longer appointment  <input type="checkbox"/> First or <input type="checkbox"/> Last appointment  <input type="checkbox"/> Pictures to help you understand  <input type="checkbox"/> Other            .....         </p>
	<p>Did someone help you to fill in this questionnaire?</p>	<p> <input type="checkbox"/> Yes      <input type="checkbox"/> No         </p>
	<p>Would you like someone to attend your health check with you?</p>	<p>           Yes -      <input type="checkbox"/> Unpaid Carer   <input type="checkbox"/> Paid Carer  <input type="checkbox"/> Friend   <input type="checkbox"/> GP Chaperone Service  <input type="checkbox"/> No         </p>

## Background





### Long Term Condition Review

	<p>Do you have any worries about your disability since your last review?</p>	<p> <input type="checkbox"/> Yes      <input type="checkbox"/> No         </p>
	<p>How do you tell someone if you are ill or in pain?</p>	<p> <input type="checkbox"/> Own words   <input type="checkbox"/> Sounds   <input type="checkbox"/> Gestures  <input type="checkbox"/> Pictures         </p>
	<p>Do you have problems with eating, drinking or swallowing?</p>	<p> <input type="checkbox"/> Yes      <input type="checkbox"/> No         </p>
	<p>Can you choose what you would like to eat and drink?</p>	<p> <input type="checkbox"/> Yes      <input type="checkbox"/> No         </p>
	<p>Do you have any special dietary needs or a feeding tube?</p>	<p> <input type="checkbox"/> Yes      <input type="checkbox"/> No         </p>

## Other known long-term health conditions

	<p>Do you have epilepsy?</p>	<p><input type="checkbox"/> Yes – my epilepsy Doctor / Nurse is .....</p> <p><input type="checkbox"/> No</p>
	<p>Do you have diabetes?</p>	<p><input type="checkbox"/> Yes – my diabetic Doctor / Nurse is .....</p> <p><input type="checkbox"/> No</p>

## Care Team




	<p><b>Next of Kin</b> This is your closest family member or your first point of contact in an emergency</p>	<p>Name:</p> <p>Their telephone number:</p>
	<p><b>Family Carer</b></p>	<p>Name:</p> <p>Their telephone number:</p>
	<p><b>Paid Carer or Support Worker</b></p>	<p>Name:</p> <p>Their telephone number:</p>
	<p>Would you like your GP Practice to share the result of your health check with the people who help to care for you?</p>	<p><input type="checkbox"/> Yes - .....</p> <p><input type="checkbox"/> No</p>

## Support

### I need help with




	Bathing	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Sometimes
	Dressing	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Sometimes
	Help with meals	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Sometimes
	Drinking	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Sometimes
	Going to the toilet	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Sometimes




### Where I live



	<input type="checkbox"/> With my family / friends <input type="checkbox"/> In a residential care or nursing home <input type="checkbox"/> In my own house or flat <input type="checkbox"/> Supported accommodation		
	Are you able to move around easily where you live?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you use mobility aids?	<input type="checkbox"/> Yes – I use a <input type="radio"/> wheelchair <input type="radio"/> a stick / frame <input type="checkbox"/> No	

## Lifestyle and Wellbeing

### Health Promotion

	<p>How much exercise / movement do you do?</p>	
	<p>Do you drink alcohol? Drinks like wine, beer, cocktails.</p>	<p><input type="checkbox"/> Yes – How much? .....</p> <p><input type="checkbox"/> No</p>
	<p>Do you smoke? This includes cigarettes and e-cigarettes.</p>	<p><input type="checkbox"/> Yes – How much? .....</p> <p><input type="checkbox"/> No</p>


	<p>Are you in a relationship?</p>	<p><input type="checkbox"/> Yes      <input type="checkbox"/> No</p>
	<p>Have you had a sexual health check?</p>	<p><input type="checkbox"/> Yes      <input type="checkbox"/> No</p>
	<p>Do you use contraception?</p>	<p><input type="checkbox"/> Yes      <input type="checkbox"/> No</p>

	<p><b>Social Prescriber</b> Would you like information about this health and wellbeing service?</p>	<p><input type="checkbox"/> Yes      <input type="checkbox"/> No</p>
 <p>Day Centre</p>	<p>Do you attend a day centre?</p>	<p><input type="checkbox"/> Yes      <input type="checkbox"/> No</p>





# Physical Health










## Me at my best - do you know your normal....?

This is just a guide for your GP Practice. You can leave page 6 blank if you do not know the answer.



	<p>Blood Pressure</p>	
	<p>Pulse</p>	
	<p>Temperature</p>	
	<p>Breathing Rate</p>	
	<p>Weight</p>	
	<p>Waist measurement</p>	
	<p>Height</p>	
	<p>BMI (this measure takes your height and weight to work out if your weight is healthy)</p>	


	Do you go to the dentist?	<input type="checkbox"/> Yes – last seen ..... <input type="checkbox"/> No
	Do you go to the optician?	<input type="checkbox"/> Yes – last seen ..... <input type="checkbox"/> No
	Do you have your hearing checked?	<input type="checkbox"/> Yes – last seen ..... <input type="checkbox"/> No
	Do you have your feet checked?	<input type="checkbox"/> Yes – last seen ..... <input type="checkbox"/> No

	Do you have heart problems?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you have breathing problems?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you have pains in your chest or get puffed out easily?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you find it hard to bend?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you find it hard to hold things?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you find it hard to walk?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you have any unusual bruises or sores?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Have you noticed any changes to your moles?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you have problems going for a wee or poo?	<input type="checkbox"/> Yes <input type="checkbox"/> No





## Mental Health

### How are you feeling?



	<p>Have you been feeling low, sad or depressed?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<p>Have you been feeling anxious or worried?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<p>Have you little interest or pleasure in doing things?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<p>Have you started to have mood swings?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<p>Do you have problems sleeping?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No

### Dementia




	<p>Do you think you have forgotten more things?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<p>Do you worry about your memory or feeling confused?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No

# Screening

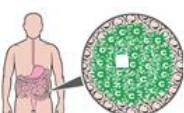
## Screening (For women only)

	<p>Latest Breast Screening</p> <p>- Do you know how to check your breasts?</p>	
	<p>Latest Cervical Screening</p>	

## Screening (For men only)




	<p>Latest Testicular Screening</p> <p>- Do you know how to check your balls?</p>	
	<p>For men over 50 years: Have you had prostate screening?</p>	
	<p>For men age 65 to 74 years: Have you had AAA screening? This checks the blood vessel that runs from your heart down through your tummy.</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No

## Screening (For men and women)

	<p>Latest Bowel Screening</p>	
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(Above images courtesy of Macmillan.org.uk in partnership with CHANGE)



## Recent Vaccinations in the last 12 months

	<p>Have you had your flu vaccination?</p>	<p><input type="checkbox"/> Yes      <input type="checkbox"/> No</p>
	<p>Have you had a vaccination for pneumonia and bronchitis?</p>	<p><input type="checkbox"/> Yes      <input type="checkbox"/> No</p>
	<p>Have you had your covid vaccination and booster?</p>	<p><input type="checkbox"/> Yes      <input type="checkbox"/> No</p>


## Drugs

This is just a guide for your GP Practice. You can leave these boxes blank if you do not know the answer.

### Medication Review

	<p>Date of your last medication review</p>	
	<p>Antipsychotic medication review (STOMP)</p>	

### Allergies

	<p>Do you have any allergies or sensitive to any medication?</p>	<p><input type="checkbox"/> Yes – I am allergic to          .....</p> <p><input type="checkbox"/> No</p>
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## Resources

Would you like Easy Read information about how to stay well and healthy?

	The Community Learning Disability Team	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Resources developed by the Gloucestershire LeDeR programme	<input type="checkbox"/> Yes <input type="checkbox"/> No



If you have any questions about your health and wellbeing, you can write them in the space below.



Thank you for completing this pre-assessment questionnaire.

Please post or deliver your questionnaire back to your GP Practice: -



Name & Address of GP Practice



Produced by Gloucestershire Health and Care NHS Foundation Trust, Learning Disability Health Facilitation Team and LD Annual Health Check Project Group. Easy read content checked by Inclusion Gloucestershire, Experts by Experience. Images courtesy of Photosymbols unless stated.

Review September 2023

For completion by GP Practice

Snomed Completion Codes for annual health check		Codes - annual health check declined/DNA	
Concept ID		Concept ID	
199751000000100	Learning disabilities annual health assessment	514021000000103	LD annual health assessment declined
<b>And as part of the Annual Health assessment, please also complete or review LD Health Check Action Plan and record appropriate code below:</b>		514041000000105	Did not attend learning disabilities annual health assessment
712491005	Completion of learning disabilities health action plan	413162002	LD health action plan declined
413163007	Learning disabilities health action plan reviewed		