

# My Health Check

## PRE-ASSESSMENT QUESTIONNAIRE



We would like to invite you to your Annual Health Check









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.

2. You may like to complete the questionnaire over several days during the **NEXT 2 WEEKS**.
3. After you have returned your completed questionnaire, your GP Practice will tell you the **DATE** of your health check.

## About Me


|   |               |  |
|---|---------------|--|
|  | My name       |  |
|  | Date of birth |  |

|   |                      |  |
|---|----------------------|--|
|    | My address           |  |
|    | Home Telephone No.   |  |
|  | Mobile Telephone No. |  |
|  | Email Address        |  |


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

How would you like your GP Practice to contact you?


Tick a box

|   |  |
|---|--|
|  | <p> <input checked="" type="checkbox"/> Phone Call      Home <input type="checkbox"/> or Mobile <input type="checkbox"/><br/> <input type="checkbox"/> Text      <input type="checkbox"/> Email      <input type="checkbox"/> Easy Read letter <input type="checkbox"/><br/> <input type="checkbox"/> My carer <input type="checkbox"/> </p> <p>Their name is: <input style="border: 1px dashed gray; width: 600px; height: 30px;" type="text"/></p> |
|---|--|

What changes can your GP Practice make to help you attend your health check?

|   |   |
|---|---|
|  | <p>Longer appointment <input type="checkbox"/> First <input type="checkbox"/> or Last appointment <input type="checkbox"/></p> <p>Pictures to help me understand <input type="checkbox"/></p> <p>Other <input type="checkbox"/> <input style="border: 1px dashed gray; width: 500px; height: 20px;" type="text"/></p> |
|---|---|

Would you like someone to attend your health check with you?

|   |   |
|---|---|
|  | <p><input type="checkbox"/> Yes: Family member <input type="radio"/> Carer <input type="radio"/> Friend <input type="radio"/> GP Chaperone <input type="radio"/></p> <p><input type="checkbox"/> No</p> |
|---|---|

## Background

### Long Term Condition Review

Tick a box

|   |  |   |
|---|--|---|
|  | <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"/> By talking <input type="checkbox"/> Sounds<br/> <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

Tick a box



Do you have epilepsy?

Yes – my epilepsy Doctor / Nurse is

Name:

No



Do you have diabetes?

Yes – my diabetic Doctor / Nurse is

Name:

No

## Care Team

Next of Kin:

This is your closest family member or your first point of contact in an emergency



Name:

Their telephone number:

## Family Carer



Name:

Their telephone number:

## Paid Carer or Support Worker



Name:

Their telephone number:

Would you like your GP Practice to share the result of your health check with the people who help to care for you?



Yes

Name:

No

# Support





## I need help with

Tick a box

|  |                     |                              |                             |                                    |
|--|---------------------|------------------------------|-----------------------------|------------------------------------|
|   | 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




Tick a box



|   |   |                                     |   |
|---|---|-------------------------------------|---|
|  | <input type="checkbox"/> With my family / friends <input type="checkbox"/> In a residential care or nursing home<br><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 equipment to move around?  | <input type="checkbox"/> Yes        | <input type="checkbox"/> No                                       |
|  | I use a.....  | <input type="checkbox"/> wheelchair | <input type="checkbox"/> a stick <input type="checkbox"/> a frame |

# Lifestyle and Wellbeing

## Health Promotion

|   |  |  |
|---|--|--|
|  | <p>How much exercise / movement do you do?<br/>This includes walking, sport, dance, swimming, keep fit</p> |  |
|  | <p>Do you drink alcohol?<br/>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 vaping</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> |







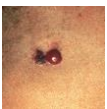

|   |   |  |
|---|---|--|
|                    | <p><b>Social Prescriber</b><br/>Would you like information about this health and wellbeing service?</p> | <p><input type="checkbox"/> Yes      <input type="checkbox"/> No</p> |
|  <p>Day Centre</p> | <p>Do you attend a day centre?</p>  | <p><input type="checkbox"/>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

# Physical Health

## General Wellbeing

Tick a box








|   |                                   |                              |                             |
|---|-----------------------------------|------------------------------|-----------------------------|
|          | Do you go to the dentist?         | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
|          | Do you go to the optician?        | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
|          | Do you have your hearing checked? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| <br>Feet | Do you have your feet checked?    | <input type="checkbox"/> Yes | <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 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?

Tick a box

|   |  |  |
|---|--|--|
|    | <p>Have you been feeling low, sad or depressed?</p>          | <p><input type="checkbox"/> Yes      <input type="checkbox"/> No</p> |
|    | <p>Have you been feeling anxious or worried?</p>             | <p><input type="checkbox"/> Yes      <input type="checkbox"/> No</p> |
|    | <p>Have you little interest or pleasure in doing things?</p> | <p><input type="checkbox"/> Yes      <input type="checkbox"/> No</p> |
|  | <p>Have you started to have mood swings?</p>                 | <p><input type="checkbox"/> Yes      <input type="checkbox"/> No</p> |
|  | <p>Do you have problems sleeping?</p>                        | <p><input type="checkbox"/> Yes      <input type="checkbox"/> No</p> |
|  | <p>Do you think you have forgotten more things?</p>          | <p><input type="checkbox"/> Yes      <input type="checkbox"/> No</p> |
|  | <p>Do you worry about your memory or feeling confused?</p>   | <p><input type="checkbox"/> Yes      <input type="checkbox"/> No</p> |



# Screening

## Screening (For women only)

Tick a box



Do you know how to check your breasts?

Yes       No

## Screening (For men only)

Tick a box



Do you know how to check your balls?

Yes       No

(Above images courtesy of Macmillan.org.uk in partnership with CHANGE)

## Vaccinations in the last 12 months

Tick a box



Have you had your flu vaccination?

Yes       No



Have you had a vaccination for pneumonia and bronchitis?

Yes       No



Have you had your covid vaccination and booster?

Yes       No

## Allergies

Tick a box



Do you have any allergies or sensitive to any medication?



Yes – I am allergic to

.....

No



## Medication

### How do you prefer to take your medication?

|   |         |                              |                             |
|---|---------|------------------------------|-----------------------------|
|  | Tablets | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
|  | Liquid  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
|   | Other   |                              |                             |

## Resources

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

|   |  |  |
|---|--|--|
|  | The Community Learning Disability Team                     | Gloucester CLDT 01452 894280<br>Stroud CLDT 01453 563103<br>Forest CLDT 01594 593075<br>Cheltenham CLDT 01242 634300                 |
|  | Resources developed by the Gloucestershire LeDeR programme | <a href="http://www.inclusiongloucestershire.co.uk">www.inclusiongloucestershire.co.uk</a><br>>Engagement in the community<br>>LeDeR |

For Easy Read Health Leaflets and films

Scan this QR code with your mobile phone

It will take you to a website called Easy Health

<https://www.easyhealth.org.uk/>

Membership to EasyHealth.org.uk is

**FREE**

Once registered you will have access to lots of accessible health resources





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

Please turn to Page 11 as this information is for your 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      |  |   |



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 and Gloucestershire Health and Care NHS Foundation Trust Partnership and Inclusion Team Experts by Experience. Images courtesy of Photosymbols unless stated.

If you need more information or hard copies of this document, please call 0800 019 3346

Version: 2

Review: September 2023