

# 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	
	My 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 ☒

	 Phone Call	Home <input type="checkbox"/> or Mobile <input type="checkbox"/>
	 Text <input type="checkbox"/>	 Email <input type="checkbox"/>  Easy Read letter <input type="checkbox"/>
	 My carer <input type="checkbox"/>	
<div style="border: 1px dashed gray; padding: 10px; margin-top: 10px;">         Their name is:       </div>		

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



Longer appointment ☐ First appointment ☐ Last appointment ☐  
 Pictures to help me understand ☐  
 Other ☐

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








☐ Yes: Family member ☐ Friend ☐ GP Chaperone ☐  
 Carer ☐ How would you like them to be involved?  
  
☐ No

## Background



### Long Term Condition Review

Tick a box ☒

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

## Other known long-term health conditions


Tick a box ☒

	<p>Do you have epilepsy?</p>	<p><input type="checkbox"/> Yes – my epilepsy Doctor / Nurse is</p> <p>Name: <input type="text"/></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>Name: <input type="text"/></p> <p><input type="checkbox"/> No</p>


## Care Team

Next of Kin:


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

	<p>Name: <input type="text"/></p> <p>Their telephone number: <input type="text"/></p>
---	---


## Family Carer

	<p>Name: <input type="text"/></p> <p>Their telephone number: <input type="text"/></p>
---	---

## Paid Carer or Support Worker

	<p>Name: <input type="text"/></p> <p>Their telephone number: <input type="text"/></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><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Name: <input type="text"/></p>
---	---

## 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 <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? This includes walking, sport, dance, swimming, keep fit</p>	
	<p>Do you drink alcohol? Drinks like wine, beer, cocktails</p>	<p><input type="checkbox"/> Yes – How much? ..... <input type="checkbox"/> No</p>
	<p>Do you smoke? This includes cigarettes and vaping</p>	<p><input type="checkbox"/> Yes – How much? ..... <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>







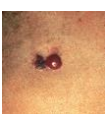

	<p><b>Social Prescriber</b> Would you like information about this health and wellbeing service?</p>	<p><input type="checkbox"/> Yes      <input type="checkbox"/> No</p>
 <p>Day Centre</p>	<p>Do you attend a day centre?</p>	<p><input type="checkbox"/> Yes      <input type="checkbox"/> No</p>

# Physical Health

## 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
	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 with constipation? Going for a wee or poo?	<input type="checkbox"/> Yes <input type="checkbox"/> No

# Mental Health

How are you feeling?

Tick a box ☒

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



## 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

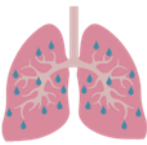
Tick a box ☒



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 (CLDT)	Gloucester CLDT    0300 421 3134 Stroud CLDT        01453 563103 Forest CLDT         01594 593075 Cheltenham CLDT    01242 634300
	Resources developed by the Gloucestershire LeDeR programme	<a href="http://www.inclusiongloucestershire.co.uk">www.inclusiongloucestershire.co.uk</a> >Engagement in the community >LeDeR

For Easy Read health leaflets and films



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

It will take you to a website called Easy Health

Membership to  
EasyHealth.org.uk is

**FREE**

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

	<p>The RESPECT form is a short plan about what should happen if you need health care or treatment in an emergency. Understanding what matters most in your life helps to make a better plan.</p>	
	<p>Do you have a ReSPECT form?</p>	<p><input type="checkbox"/> Yes      <input type="checkbox"/> No</p>

### For ReSPECT Easy Read Guides:



<https://www.resus.org.uk/respect/respect-resources> 

**For ReSPECT films:** [https://youtu.be/vy\\_slyOuPAE](https://youtu.be/vy_slyOuPAE) - Jenny's Story - 9 mins

<https://youtu.be/Yrq1zQotkaY> - John's story - 7 mins

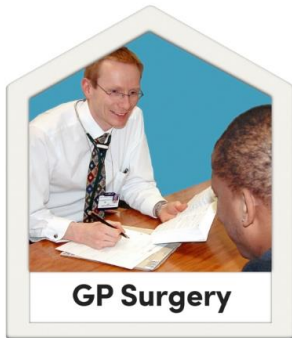


If you have any questions about your health and wellbeing, you can write them in the space below.



Thank you for completing this pre-assessment questionnaire.

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



Name & Address of GP Practice

This box contains information 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	1323481000000100	Adult not brought to appointment

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.