



Stay **SUPERCHARGED**
and fully fit by having
your Annual Health Check

For anyone with a
Learning Disability aged 14+



Step 1: COVID -19 may mean that you have a remote / virtual Annual Health Check.

Step 2: It is important you complete this questionnaire and send it back to your GP surgery. This will help your Doctor to arrange a face to face or remote Annual Health Check.

My name is _____

I like to be called _____

My date of birth is _____

The date of my
Health Check is



My preferred communication method to help me understand:-

- Speaking
- Signing
- Pictures
- Using a communication aid
- Easy Read
- Using gestures or pointing

This is the name of the person who looks after me:-

Family Carer _____

Paid Carer _____



Where do you currently live?

- With family or friends In my own house / flat
 In a residential care home In supported living
 Other -----

Do you have a job? ✓ Yes ✗ No

If yes, what is your job?



Any known health problems?

- Epilepsy Diabetes
 Heart problem Lung / breathing problem

Do you have any allergies? -----

Can you easily **tell** people if you are ill or in pain? ✓ Yes ✗ No

If you answered no—how would someone know if you were ill or in pain?
(e.g. facial expressions, pictures, noises)

If known, what are your **normal observations**?

Blood Pressure ----- Pulse -----

Temperature ----- Breathing Rate -----

What is your current weight? -----

Has your weight changed? ✓ Yes ✗ No

How tall are you? -----

Are you able to **move around** easily? ✓ Yes ✗ No

Do you use mobility aids? (e.g. a wheelchair, stick, frame)

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

It's worse

It's the same

It's better



What **exercise** do you do?

Do you drink **alcohol**?

✓ Yes

✗ No

Do you **smoke**?

✓ Yes

✗ No

Do you go to the **dentist**?

✓ Yes

✗ No

When was your last appointment?

Do you go to the **optician**?

✓ Yes

✗ No

When was your last appointment?

Have you had your **feet** checked?

✓ Yes

✗ No

When was your last appointment?

Have you had your **hearing** checked?

✓ Yes

✗ No

When was your last appointment?

Do you find it hard to **bend**?

✓ Yes

✗ No

Do you find it hard to **hold things**?

✓ Yes

✗ No

Do you find it hard to **walk**?

✓ Yes

✗ No

If you have **epilepsy**, please answer the following questions:-

Who is your epilepsy doctor or nurse? -----

When was your last appointment? -----

How many seizures do you have a month? -----

Is there anything you want to tell me about your epilepsy?

Have there been any **big changes** in your life?

(e.g. moving house, a death)

✓ Yes ✗ No

Do you **self-harm**?

✓ Yes ✗ No

Have there been any other changes to your **mental health**?

Do you have any **worries**?

✓ Yes ✗ No

Do you think you have **forgotten** more things? ✓ Yes ✗ No

Have you started to have **mood swings**? ✓ Yes ✗ No

Do you have any problems **sleeping**? ✓ Yes ✗ No

Do you take any tablets or medicines other than those prescribed by your doctor? ✓ Yes ✗ No

If yes, are they vitamins, painkillers, laxatives or something else?

Are you in a relationship? ✓ Yes ✗ No

Do you use contraception? ✓ Yes ✗ No

Have you had a sexual health check? ✓ Yes ✗ No

- Do you have problems going to the toilet? ✓ Yes ✗ No
- If **yes**, do you have problems going for a wee? ✓ Yes ✗ No
- Do you have problems going for a poo? ✓ Yes ✗ No
- Are you between 60 and 74 years old? ✓ Yes ✗ No
- If **yes**, have you been offered bowel screening? ✓ Yes ✗ No



Your Health Check



For Women

- Have you had breast screening? ✓ Yes ✗ No
- Have you had cervical screening (smear test)? ✓ Yes ✗ No
- Have there been changes in your menstrual cycle (period)? ✓ Yes ✗ No

For Men

- Have you had your testicles (balls) checked? ✓ Yes ✗ No
- Are you between 65 and 74 years old? ✓ Yes ✗ No
- Have you had AAA screening (Abdominal Aortic Aneurysm) to check if there is a bulge or swelling in the main blood vessel that runs from your heart down through your tummy)? ✓ Yes ✗ No

Your Health Check



Have you noticed any unusual bruises or sores? ✓ Yes ✗ No

Have you noticed changes in any moles? ✓ Yes ✗ No

Have you had a flu jab in the last 12 months? ✓ Yes ✗ No

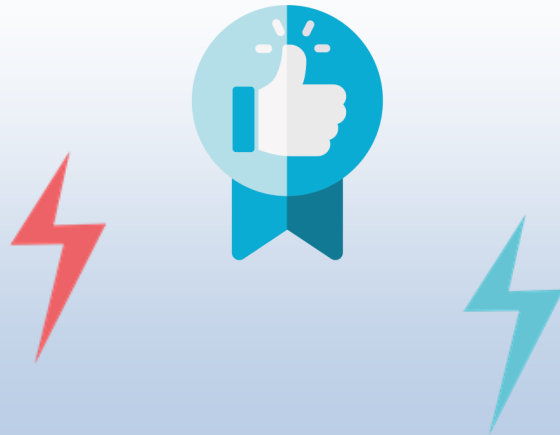
Have you ever had a jab for pneumonia and
bronchitis? ✓ Yes ✗ No

Do you have a fear of jabs? ✓ Yes ✗ No

At your Annual Health Check your

Doctor or Nurse will check your:-

- Weight
- Heart Rate
- Blood Pressure
- Blood Sample
- Urine Sample



Do you have any medical fears / phobias your Doctor or Nurse should
know about:- ✓ Yes ✗ No

If you answered yes, tell us how the Doctor or Nurse can help you to be
less anxious about your Annual Health Check?

**At the end of your Annual Health Check appointment, your Doctor or
Nurse may issue a Health Check Action Plan. Keep it safe and follow the
advice.**



**You're on your way
to getting SUPERCHARGED!**



**You can use this page if you have
any questions you would like to ask
the Doctor or Nurse at your Annual
Health Check appointment.**

Produced by the Learning Disability Health Facilitation Team in partnership with Kingfisher Treasure Seekers.

Printed copies of the Pre-Health Check Questionnaire can be obtained from the Health Facilitation Team on Tel. No. 01452 321015 or by email to Simon.Shorrick@ghc.nhs.uk.

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