

**Pre Annual Health Check**

**Questionnaire for L.D. Patients**

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| **Please fill this book in and bring it back (or email it) to your GP surgery** | | | |
|  | Name ……………………  I prefer ………………….. |  | Date of birth:  ……………………. |
|  | Who supports you? ………………………………………  ……………………………………………………………………..  …………………………………………………………………….. | | |
|  | Address: ………………………………………………………….  ……………………………………………………………………..  …………………………………………………………………….. Telephone ……………………………………………………….. | | |
|  | Email: ……………………………………………………………… | | |

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| **Consent for Summary Care Record and additional information** | | | |
| 1. | Your Doctor will have your basic summary care record.  It has information about your health, the medications which you take and any medications which might make you ill (allergic reaction)  A doctor or nurse who doesn’t know you very well, might ask to look at your Summary Care Record, this gives them the right information to care for you. | | |
| 2. | Only people like a doctor or nurse who are treating you can see your summary care record.  The Doctor can add extra information to your record with things like a history of your health problems, operations, or an illness you’ve had. It can include information about who supports you and what help or type of information you might need at appointments.  The extra information can help doctors and nurses, no matter where you are treated, look after you and help keep you well. | | |
| 3. | If you would like extra information adding to your summary care record about your health and what support you need let your Doctor know.  If you don’t want your information on your Summary Care record you can ask your doctor to remove it | | |
| <https://digital.nhs.uk/binaries/content/assets/legacy/pdf/p/6/scr_ai_easy_read_patient_leaflet.pdf> | | | |
| Do you consent to sharing information | | **Yes** | **No** |
| 1. Consent for electronic record sharing? | |  |  |
| 2. Consent for summary care record with additional information? | |  |  |
| 3. Consent to share data with another professional? (specified third party) | |  |  |

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| **Reasonable adjustments – Care Plan** | | | | |
|  | A reasonable adjustment is a small change your Doctor can make, to make your Annual Health Check easier for you.  Below are examples of reasonable adjustments or you can get help to write down what you need in the blank section. You can ask for these reasonable adjustments to be available for you at your annual health check. | | | |
| **Reasonable Adjustment** | **How you can help me** | **Yes** | **No** | **Comments** |
|  | Please add a note to my front screen that I have a learning disability |  |  |  |
| Please add a note to my front screen that I need a double appointment. |  |  |  |
| I need information in easy read |  |  |  |
| I need information in  another language – if so what language? |  |  |  |
|  | I need my carers to arrange appointments for me and to be given results of my tests etc. over the phone. |  |  |  |
|  | I use a wheelchair and will need a hoist if I need a physical examination. I may need a home visit in this instance. |  |  |  |
|  | I find it difficult to wait in the doctors for my appointment, as it may make me anxious.  I may need to wait outside until you are ready to see me. |  |  |  |

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|  | I may need to visit the surgery before my appointment to feel comfortable in the  environment. |  |  |  |
| I need time to process  information and answer questions. |  |  |  |
|  | Bright lights or loud noises may affect me. |  |  |  |
| My carer will support you to understand my needs. |  |  |  |
| Other reasonable adjustments? |  | | | |
| Flu | | | | |
|  | | **Yes** | **No** | **Comments** |
|  | Have you had your nasal spray or flu vaccine injection? |  |  |  |
| <https://www.ndti.org.uk/uploads/files/Flu_Injection_resource.pdf> | | | | |

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| Mobility | | | | |
|  | | **Yes** | **No** | **Comments** |
| Stiffness or difficulty moving |  |  |  |  |
| Slowing of movements |  |  |  |  |
| Pain when moving |  |  |  |  |
| Falling or tripping |  |  |  |  |
| Changes in posture/mobility |  |  |  |  |
| Mobility equipment used |  |  |  |  |
| Swelling or redness in  limbs/skin |  |  |  |  |
| Health Screening - Women | | | | |
|  | | **Yes** | **No** | **Comments** |
| **25 +** | Have you had a smear test? |  |  |  |
| <https://www.jostrust.org.uk/sites/default/files/isl116_18_er_smear_tests_final_low_res.pdf> | | | | |
|  | Change in periods e.g. heavy bleeding in between periods, painful periods, Vaginal discharge |  |  |  |
| If there is a problem then please bring your menstrual chart with you if you have one. | | | | |
|  | If you are over 50 have you had a mammogram?  <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/765594/Easy_guide_to_breast_screening.pdf> |  |  |  |



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| Health Screening - Men | | | | | |
|  | | | **Yes** | **No** | **Comments** |
| **65 +** | | Have you had your Abdominal Aortic Aneurysm or AAA Screening? |  |  |  |
| <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/465583/AAA_easy_read_invitation_leaflet_final.pdf> | | | | | |
|  | | Do you check your own testicles / balls |  |  |  |
|  | | Have you felt/noticed any changes to your testicles/balls? |  |  |  |
| Sexual Health | | | | | |
|  | | | **Yes** | **No** | **Comments** |
|  | | Are you sexually active? |  |  |  |
|  | | Do you use anything to stop you getting pregnant or sexually transmitted infections |  |  |  |
|  | Weight | | | | |
|  | | | **Yes** | **No** | **Comments** |
| Has your weight changed? | | |  |  |  |
| If there is a problem then please bring your weight chart if you have one. | | | | | |



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| Dentist | | | |
|  | **Yes** | **No** | **Comments** |
| Do you have a dentist? When was your last visit? |  |  |  |
| Do your teeth hurt? |  |  |  |
| Do your gums bleed? |  |  |  |
| Do you have a swelling or a lump? |  |  |  |
| Do you have difficulty eating? |  |  |  |
| Eyes | | | |
|  | **Yes** | **No** | **Comments** |
| When did you last have your eyes tested |  |  |  |
| Do you have any eyesight problems or wear glasses |  |  |  |
| Hearing | | | |
|  | **Yes** | **No** | **Comments** |
| Have you noticed any problems or changes to your  hearing? |  |  |  |
| Have you visited a hearing clinic (audiologist)? |  |  |  |

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| Breathing | | | |
|  | **Yes** | **No** | **Comments** |
| Coughing that won’t go away (more than 3 weeks) |  |  |  |
| Chest infection |  |  |  |
| Coughing up blood |  |  |  |
| Unusual coloured spit |  |  |  |
| Wheeze |  |  |  |
| Hay fever, allergies, asthma or chronic obstructive pulmonary disease |  |  |  |
| Breathlessness |  |  |  |
| Do you smoke? |  |  |  |
| Eating and Drinking | | | |
|  | **Yes** | **No** | **Comments** |
| Indigestion – tummy ache when you eat |  |  |  |
| Food allergies/intolerances |  |  |  |
| Being sick |  |  |  |
| Do you drink alcohol |  |  |  |
| Do you eat inedible food? |  |  |  |
| Difficulty swallowing |  |  |  |
| Coughing when eating or drinking |  |  |  |

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| Bowels | | | |
|  | **Yes** | **No** | **Comments** |
| Constipation – hard poo or can’t go to the toilet |  |  |  |
| Diarrhoea– watery poo and going too much |  |  |  |
| Bleeding from your bottom |  |  |  |
| Difficulty getting to the toilet on time |  |  |  |
| Changes in bowel pattern |  |  |  |
| Fatigue |  |  |  |
| Are you aged 60-74? Have you received your bowel screening kit? |  |  |  |
| <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/598296/easy_guide_bowel_cancer_screening.pdf> |  |  |  |
| Urine | | | |
|  | **Yes** | **No** | **Comments** |
| Pain when you wee? |  |  |  |
| Urine infection |  |  |  |
| Wee more often? |  |  |  |
| Do you find it difficult to start weeing? |  |  |  |
| Does your wee start and stop when you are weeing? |  |  |  |
| Blood in your wee |  |  |  |
| Difficulty in getting to the toilet in time? |  |  |  |

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| Breasts | | | |
|  | **Yes** | **No** | **Comments** |
| Any lumps in breasts or armpits? |  |  |  |
| Any liquid from your nipple? |  |  |  |
| Any changes in the shape of your breasts? |  |  |  |
| Any changes to the skin on your breasts? |  |  |  |
| Any changes to shape of your nipples? |  |  |  |
| Do you have a change in colour to your breasts or nipples? |  |  |  |
| Do you get tired more easily? |  |  |  |
| <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/765594/Easy_guide_to_breast_screening.pdf> | | | |
| Menopausal symptoms | | | |
|  | **Yes** | **No** | **Comments** |
| Do you feel tired? |  |  |  |
| Do you have mood swings? |  |  |  |
| Do you feel sad? |  |  |  |
| Do you feel irritable? |  |  |  |
| Do you have hot flushes? |  |  |  |

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| Brain | | | |
|  | **Yes** | **No** | **Comments** |
| Do you have epilepsy? |  |  |  |
| How many seizures per month? |  |  |  |
| Any changes to seizure? |  |  |  |
| Under the care of an epilepsy specialist(neurologist) |  |  |  |
| When did you last see them? |  |  |  |
| Triggers for Epilepsy e.g. lights, TV, tired , temperature, infections |  |  |  |
| Do you take your epilepsy medication regularly & as prescribed? |  |  |  |
| Do you have any side effects i.e. dizzy, sick, vision, irritable? |  |  |  |
| **Have you had any of the following:** | **Yes** | **No** | **Comments** |
| Stroke |  |  |  |
| Fainting |  |  |  |
| Blackouts |  |  |  |
| Pins and needles |  |  |  |
| Arm or leg weakness |  |  |  |
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| Heart | | | | |
|  | | **Yes** | **No** | **Comments** |
| Difficult or labored breathing during the day and at night | |  |  |  |
| Chest pain when exercising | |  |  |  |
| Palpitations – feeling your heart beat | |  |  |  |
| Any swelling to the ankles, hands or body ect? | |  |  |  |
|  | Diabetes | | | |
|  | | **Yes** | **No** | **Comments** |
| Do you test your blood sugar regularly? | |  |  |  |
| Have you been for your diabetic eye screening? | |  |  |  |
| Please bring your blood sugar charts if you have them | | | | |
| Pain | | | | |
|  | | **Yes** | **No** | **Comments** |
| Do you have any pain which has lasted more than 12 weeks? | |  |  |  |
| Does your pain relief medicine help to stop or reduce the pain? | |  |  |  |

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|  | Skin | | | |
|  | | **Yes** | **No** | **Comments** |
| Dry or Itchy Skin | |  |  |  |
| Prescribed Skin Cream | |  |  |  |
| Warts | |  |  |  |
| Cold Sores | |  |  |  |
| Sores or open wounds | |  |  |  |
| Pressure area concerns | |  |  |  |
|  | Mental Health | | | |
|  | | **Yes** | **No** | **Comments** |
| Any Worries about your Memory or confusion | |  |  |  |
| Are you low, sad or unhappy? | |  |  |  |
| Are you worried, frightened or anxious? | |  |  |  |
| Do you feel like crying? | |  |  |  |
| Have you injured yourself since your last review? | |  |  |  |
| Do you feel like you can’t cope or look after yourself? | |  |  |  |
| Do you feel irritable, aggressive or violent? | |  |  |  |
| Have you thought about harming yourself or actually harmed yourself? | |  |  |  |
| Do you hear voices or see things? | |  |  |  |
| Have you spoken to someone to about how you feel? | |  |  |  |

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| Feet | | | | |
|  | | **Yes** | **No** | **Comments** |
| Have you been to a podiatrist (foot specialist)? When did you last go? | |  |  |  |
| If no, who cuts your nails? | |  |  |  |
| Do you have any pain in your feet? | |  |  |  |
| Medication Review | | | | |
|  | Your Doctor will talk to you about your medication and look at whether your medication is right for you.  People with a learning disability are sometimes given medication they don’t need; your doctor will talk to you if he needs to change yours.  For more information go to:  <https://www.vodg.org.uk/wp-content/uploads/2017-VODG-Preparing-to-visit-a-doctor-to-talk-about-psychotropic-medication.pdf> | | | |
|  | How do you take your medication? | | | |
| Can you swallow a tablet? | | | |
| Do you need liquid medication? | | | |
| Do you have any problems with taking your medication? | | | |
| Are you worried about the effect the medication is having on you? | | | |
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| Hospital Passport | | | | | |
|  | | | **Yes** | **No** | **Comments** |
| Do you have a hospital Passport? This helps hospital staff understand how to help you | | |  |  |  |
|  | | | | | |
| Palliative Care | | | |  | |
|  | | | **Yes** | **No** | **Comments** |
| Are you receiving support from palliative care services like a hospice or Marie Curie Nurse? | | |  |  |  |
| End of Life Gold Standard Framework | | | | | |
|  | | | **Yes** | **No** | **Comments** |
| DNAR or Respect Document, any concerns or questions about these documents? | | |  |  |  |
|  | | |  |  |  |
| Housing |  | |  |  |  |
|  | Who do you live with?  Do you have carers? How often?  What do they help you with? | | | | |
| Bring a helper | |  | | | |
|  | | You can ask questions at your health check.  You can bring someone with you who can help you in the appointment. | | | |
| Do you have any questions? | | | | | |
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|  | **Thank you for completing this form.**  **Please bring it with you to the health check appointment** |
|  | |

Dr Zafar & Partners

Rillwood Medical Centre

Tonmead Road

Lumbertubs

Northampton

Northamptonshire

NN3 8HZ

Email: [rillwood.k83020@nhs.net](mailto:rillwood.k83020@nhs.net)

Website: <https://www.rillwoodmedicalcentre.nhs.uk/>

**NOTES:**