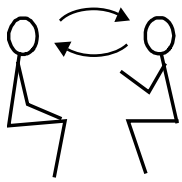
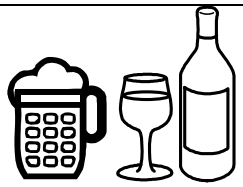
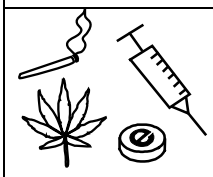
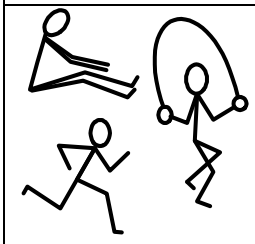
Health Check for People with a Learning Disability

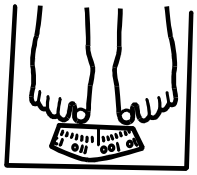
Please fill in these pages with the help of your carer (if you have one) before you come and visit the doctor.

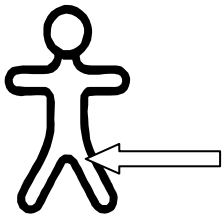
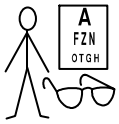
Please bring with you all your **medicines** whether prescribed by the doctor or not, your **health action plan** if you have one and a **urine sample** in a small bottle.

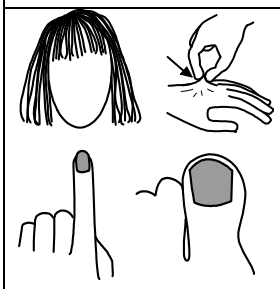
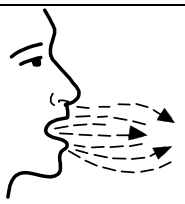
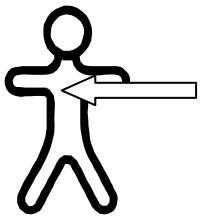
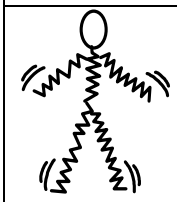
Date of health check	
Name	
Date of Birth	
Male / Female	
Address	
Main Carer	
Key social care contact (name and contact details)	
Health facilitator (name and contact details)	

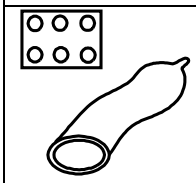
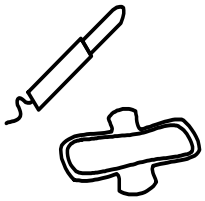
	Do you have a Health Action Plan? Yes ☐ No ☐ If so, please fill it out and bring with you to your appointment
 English ਪੰਜਾਬੀ اُردو हिन्दी ગુજરાતી العربية język polski 粵語 shqip	The language I speak and understand best is

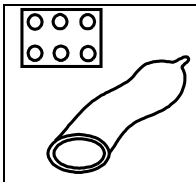
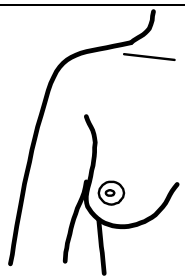
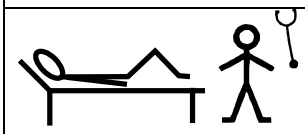
	Do have any difficulty in communicating? Yes ☐ No ☐ If you do, what help do you need to communicate? Do you see a speech therapist? Yes ☐ No ☐
	Do you smoke? Yes ☐ No ☐ How many cigarettes a day? If you do smoke, would you like help to stop?
	Do you drink alcohol? Yes ☐ No ☐ If so, how many units a week? (A unit is half a pint of beer or a small glass of wine or a single shot of spirits) Do you or your carer think you drink too much? Yes ☐ No ☐ Do you want help to drink less alcohol? Yes ☐ No ☐
	Do you use any recreational drugs e.g. cannabis, ecstasy etc? Yes ☐ No ☐ If Yes, do you want help to stop using these drugs? Yes ☐ No ☐
	Do you do any exercise? Yes ☐ No ☐ What exercise do you do? How often do you exercise? Would you like to do more exercise? What kind?

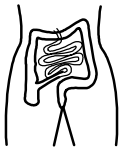
	Are you concerned about your weight? (either putting on too much weight or losing weight) Yes ☐ No ☐
 	Do you have any difficulties eating and drinking? Yes ☐ No ☐ If Yes, what help do you need with eating and drinking? Do you have any problems with swallowing? Yes ☐ No ☐ Do you have any burning pain in the centre of your chest ("heartburn") or indigestion? Yes ☐ No ☐
	Has your ability to use your hands, arms or legs changed in last year? Yes ☐ No ☐ Are you fully mobile? Yes ☐ No ☐ If not explain how mobile you are. Do you use mobility aids? (a wheelchair, stick or frame) Yes ☐ No ☐ If so, what? Has your mobility changed in the last year? Worsened ☐ Remained the same ☐ Improved ☐
	Do you have constipation or diarrhoea? Yes ☐ No ☐ Do you have pain when you pass urine? Yes ☐ No ☐ Is there any blood in your urine? Yes ☐ No ☐ Do you have any other problems when you pass urine? Yes ☐ No ☐

	Do you have any problems with continence? Urinary incontinence? Yes ☐ No ☐ Faecal incontinence? Yes ☐ No ☐ Do you have continence aids? Yes ☐ No ☐ If so, what?
	Do you have any pain in your abdomen? Yes ☐ No ☐ Have you got any swellings in your groin (just above the crease at the top of your legs)?
 	Do you have any problems with your eyes and seeing things? Yes ☐ No ☐ Date of last optician's appointment?
 	Do you or your carer have any concerns about your hearing? Yes ☐ No ☐ Do you have a hearing aid? Yes ☐ No ☐ Do you wear it? Yes ☐ No ☐ Do you visit an audiologist? Yes ☐ No ☐ Date of last appointment?
 	Do you have any problems with your teeth or mouth? Yes ☐ No ☐ If so, what? Do you visit the dentist regularly? Yes ☐ No ☐ Date of last appointment?

 	Do you have any problems with your feet? Yes ☐ No ☐ If so, what? Do you visit the podiatrist/ chiropodist? Yes ☐ No ☐ Date of last appointment?
	Do you have any problems with your hair, skin or nails? Yes ☐ No ☐ If so, what?
 	Do you have any problems with your breathing? Yes ☐ No ☐ Do you cough? Yes ☐ No ☐ Do you cough up anything? Yes ☐ No ☐
	Do have any pain in your chest? Yes ☐ No ☐ If Yes, when does the chest pain happen?
	Do you have any swelling of your ankles or feet? Yes ☐ No ☐ Do you feel you have an irregular heart beat or your heart beating fast? Yes ☐ No ☐
	In the last year have you started to shake or have movements that you cannot control? Yes ☐ No ☐ Has your carer noticed that you sometimes are not concentrating? (e.g. seem to have absences)? Yes ☐ No ☐

  	Do you have problems sleeping? Yes ☐ No ☐ Has your appetite changed recently? Yes ☐ No ☐ Do you feel sad for long periods of time and find it difficult to cheer yourself up? Yes ☐ No ☐ Do you feel anxious and worried a lot of the time? Yes ☐ No ☐ Do you or your carer think there has been a change in your ability to recognise people or places? Yes ☐ No ☐ Do you see a psychiatrist? Yes ☐ No ☐
FOR MEN:	
	Has there been any pain or swelling in your testicles? Yes ☐ No ☐
	Are you sexually active? Yes ☐ No ☐ If so, are you using condoms? Yes ☐ No ☐
FOR WOMEN:	
 	Do you have periods? Yes ☐ No ☐ Do you have any problems with your periods? Yes ☐ No ☐ Are your periods painful? Yes ☐ No ☐ Is the bleeding very heavy? Yes ☐ No ☐ Is there any irregular bleeding (between periods for example)? Yes ☐ No ☐ Do you have any vaginal discharge that is smelly or makes you sore? Yes ☐ No ☐

	Are you sexually active? Yes ☐ No ☐ If yes, are you using contraceptives?
	Have you noticed any pain or lumps in your breasts? Yes ☐ No ☐ If you are a woman aged over 50, have you been for a breast screening test? Yes ☐ No ☐ When was your last test?
	If you are a woman aged 25 to 64, have you had a cervical smear test? Yes ☐ No ☐ When was your last test?

MEN OR WOMEN: 	If you are a man or a woman and are aged 60 to 69, have you been sent a kit to test for bowel cancer? Yes ☐ No ☐ When was the last test?