Planning a Health Action Plan

Health Check Questionnaire

Please think about and fill in these questions before your health check. Don't worry if you can't answer them all. Bring this form with you to your health check.

Name .....

Do you have any of the following conditions?

- ☐ Epilepsy
- ☐ Down's Syndrome
- ☐ Autism
- ☐ Cerebral Palsy
- ☐ Communication difficulties
- ☐ Behaviour difficulties
- ☐ Mental health problems
- ☐ Diabetes
- ☐ Asthma
- ☐ Heart problems
- ☐ Blood pressure problems
- ☐ Sight problems
- ☐ Hearing problems
- ☐ Skin problems

Do any members of your family have any long term health conditions?

……

Medication (Tablets, Medicine Cream or Inhalers)

Name of Medication	Reason for taking (if known)	Dose

Do you have problems taking your medication?
Please tell us about this here.

.....

Who helps you with your medication?

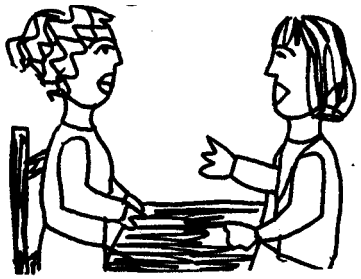
.....

Are you allergic to anything, including medication?

.....

Do you receive any help from any of these people? (please tick)

What is their name?



☐ Community Nurse _____

☐ Social Worker _____

☐ Occupational Therapist _____

☐ Speech Therapist _____

☐ Physiotherapist _____

☐ Psychiatrist _____

☐ Psychologist or other person _____

Do you have epilepsy?

☐ Yes ☐ No

How often do you have seizures (fits)?

☐ Daily ☐ Weekly

☐ Monthly ☐ Longer

What type of seizures do you have?

……..

Who helps you with your epilepsy?

……

Have you ever had a hearing test?

☐ Yes ☐ No

Have you got to have another hearing test?

Yes ☐ No ☐ When……

What are your hearing problems?

……

Do you have your eyes tested regularly?

How often?

☐ 6 months ☐ 1 year ☐ longer

Do you wear glasses? ☐ Yes ☐ No

Do you have any problems? ☐ Yes ☐ No

What problems? ……..

Who is your dentist?

……

When did you last go to the dentist?

☐ 6 months ☐ 1 year ☐ longer

Do you smoke?

☐ Yes ☐ No

How many cigarettes a day?

Do you drink alcohol?

☐ Yes ☐ No

How many drinks a day?

Do you do any exercise?

☐ Yes ☐ No

What type?

……

How often?.....

Do you eat a well balanced diet?

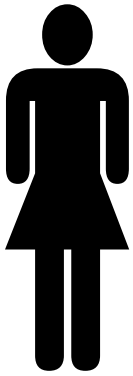
☐ Yes ☐ No

Do you eat five portions of fruit and vegetables a day?

☐ Yes ☐ No

Please say any worries you have about eating and drinking

……



If you are female have you had any of the following?

- ☐ Cervical smear
- ☐ A talk about breast awareness
- ☐ A breast X-Ray (also called a Mammogram)

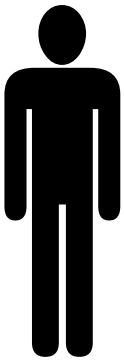
And do you ever have any of the following?

- ☐ Hot flushes
- ☐ Irregular periods
- ☐ Period pains

Do you want a separate appointment to talk about private health issues, for example contraception?

☐ Yes ☐ No

If you are male have you ever had a



☐ Well man check

☐ A talk about looking after your testicles (balls)?

Do you want a separate appointment to talk about private health issues, for example contraception?

☐ Yes ☐ No

Mental Health – How are you feeling?

How do you feel about things most of the time?

Do you feel

Happy

☐

Sad

☐

Worried

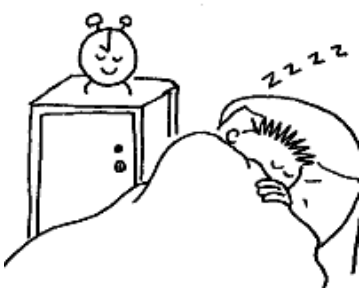
☐

Angry

☐

Do you want to talk to somebody about any difficult feelings?

☐ Yes ☐ No



Sleeping

Do you have problems sleeping?

☐ Yes ☐ No

If yes, please explain

……

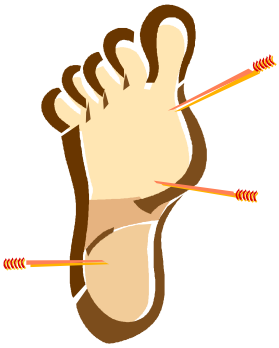
Mobility – getting around

Do you have any difficulties with your movement or getting around?

☐ Yes ☐ No

If yes, please explain

……



Do you need help to look after your feet?

☐ Yes ☐ No

Do you need to see a podiatrist, also called a chiropodist or foot doctor?

☐ Yes ☐ No

Down's Syndrome

Please fill in this section only if you have Down's Syndrome

Have you had a thyroid function (blood test) recently?

☐ Yes ☐ No

Do you have any problems with going to the toilet?

Please explain

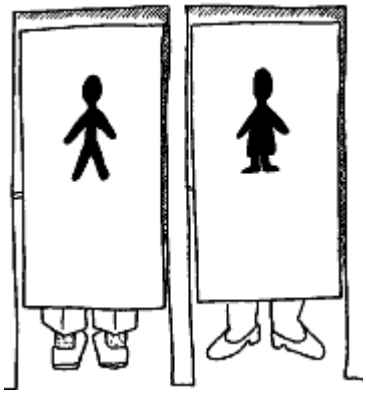
……

Do you have any questions or want to tell us anything about your health?

……..

……..

Thank you for filling in this questionnaire. <u>This is your questionnaire to keep</u>. It might be useful to take if you go into hospital or if you are developing a Health Action Plan



If you can, please bring a sample of urine (wee), in a clean bottle, with you to the appointment.

If you cannot do this, you will be asked to go to the toilet, to give us some urine, at your appointment.

<u>This page should be filled in with the nurse or GP at your health check.</u>

Date of health check……..

Name of Dr/Nurse doing health check……..

List of any new treatment needed after health check.
This information will be useful to put in a Health Action Plan

1. …….
Who will do this?
When?

2. …….
Who will do this?
When?

3. …….
Who will do this?
When?

4. ……..
Who will do this?
When?

List of any other things I need to do to keep healthy.