Resource 20

easy redd

NHS
Suffolk and North East Essex

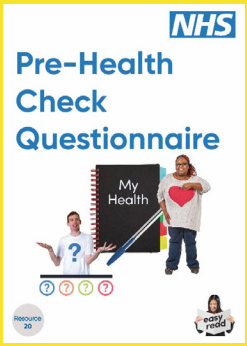
Pre-Health Check Questionnaire



Print version

Ace Anglia

About this booklet



Please fill in this booklet before you come to your Annual Health Check. You may want to ask for help from family, a friend or a support worker.



Please bring all of your medication or a list of your medication with you.



Please bring any charts you or your staff use to monitor your health.

For example, sleep charts, bowel charts, period charts, seizure charts.



Please bring your Health Action Plan, if you have one.

Please also bring a urine (wee) sample. You may need to pick up a pot from your surgery.



What is the date of your Health Check?

DAY	MONTH	YEAR

About me



Name



Date of birth

DAY MONTH YEAR



Were you born a male or female?

○ Male ○ Female

What would you describe your gender as?



Address

Vaccinations



Have you had any of these vaccinations?

Please tick yes or no

If you are unsure about dates, please leave blank and your doctor can help you fill it out.

Shingles Vaccination

Yes ○ No ○ Don't know ○

If yes, what date?

MMR (Measles Mumps and Rubella) Vaccination

Yes ○ No ○ Don't know ○

3.b. **If yes, what date?**

Pneumonia Vaccination

Yes ○ No ○ Don't know ○

3.b. **If yes, what date?**

Cervical Cancer Vaccination (HPV)

Yes ○ No ○ Don't know ○

3.b. **If yes, what date?**

Flu Vaccination

Yes ○ No ○ Don't know ○

3.b. **If yes, what date?**

Vaccinations

Covid-19 Vaccination

Yes ○ No ○ Don't know ○

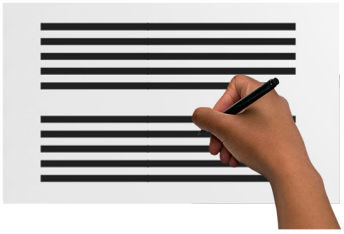
If yes, what date?

Covid-19 Vaccination Booster

Yes ○ No ○ Don't know ○

3.b. **If yes, what date?**

Other,
Please write in box



How you had any other vaccinations?

If yes, please write in the box

Covid-19



Have you had Covid-19?

Yes ○ No ○



If you had Covid-19, did you go to hospital or did you stay at home?

Covid-19

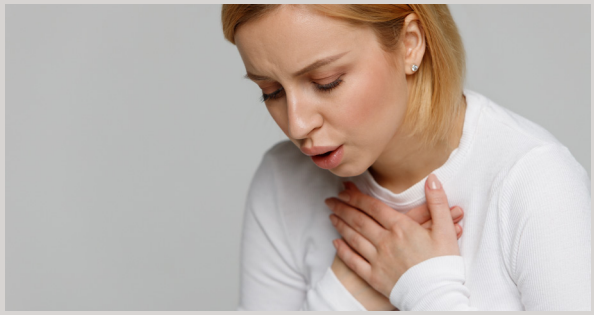
Do you still have any of the symptoms?



○ Extreme Tiredness



○ Chest pain or tightness



○ Breathlessness



○ Loss of taste or smell



○ Difficulty thinking and concentrating on things (Brain fog)



○ Muscle Ache / Numbness

Covid-19



Dizziness



Feeling sick, stomach aches or loss of appetite



Depression and Anxiety



Tinnitus / Ear Aches



Pins and needles



A high temperature, cough, headache, sore throat, changes to sense of smell or taste

Covid-19



Diarrhoea



Difficulty sleeping (Insomnia)



Rashes



Heart palpitations
Irregular heart beats



Have you had any other changes since having Covid-19?

Yes ○ No ○

If **yes,** what changes?

Covid-19



You can still get long Covid even if you've never had symptoms of Covid-19.



If you answered yes to any of these symptoms, you may have long Covid. Please speak to your doctor or nurse.

Where I live



Please tell us about where you live.

1. **What kind of place is it?**



○ **Your family home**



○ **A residential care home**



○ **Your own flat or house**



○ **Supported living home**

Employment

2.a. **Do you have a job?**



Yes ○

No ○

2.b. **If yes, what is your job?**

Medical phobias / fears



3.a. **Do you have any medical fears/phobias?**

Yes ○ No ○



3.b. **If yes, what?**

My Learning Disability



4. **Does your type of learning disability have a name** (if you do not know, leave the box blank)?



5. **Were you born with the learning disability or did something cause it** (if you do not know, leave the box blank)?

My Communication



6. **The language I speak and understand is:**

7. **How do you communicate**
(tick as many as you like)?



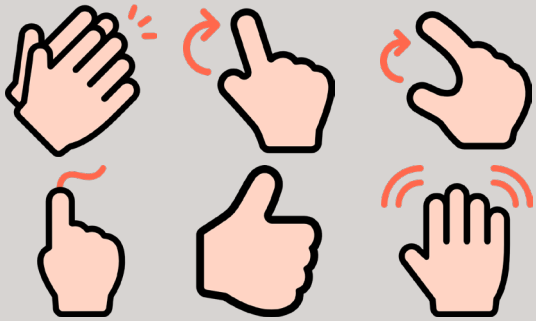
○ **Talking**



○ **Signing**



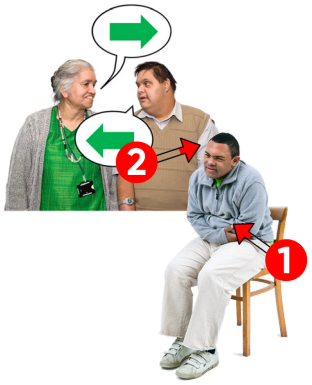
○ **Using a communication aid**



○ **Pointing and gestures**

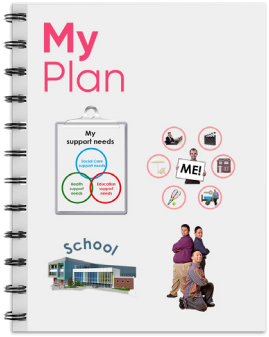
○ **Other**
Please write in the box

My Communication



8.a. **Can you easily tell people if you are ill or in pain?**

Yes ○ **No** ○



8.b. **If no, is this written in a support plan?**

Yes ○ **No** ○



9. **Do you see a speech therapist to help with your communication?**

Yes ○ **No** ○

My Communication



10.a. **Do you have any difficulty in communicating?**

Yes ○ **No** ○

10.b. **If yes, what helps you to communicate?**







My Communication



11. **What helps you to understand others?**



○ **Talking slowly**



○ **Signing**



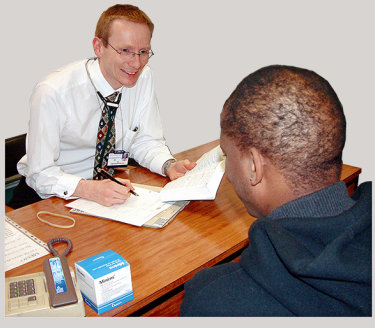
○ **Talking without jargon**



○ **Explaining with pictures**



○ **Writing things down**



○ **Taking more time when explaining**

Hot or cold drinks



12. **What hot drink do you like to drink?**



○ **Decaffinated Coffee**



○ **Coffee**



○ **Breakfast Tea**



○ **Herbal Tea**

○ **Other**
Please write in the box

Hot or cold drinks



13.a. **Do you use sugar?**

Yes ○ No ○

13.b. **If yes, how many tsp of sugar do you have?**



14.a. **Do you use sweeteners?**

Yes ○ No ○

14.b. **If yes, how many sweeteners do you have?**

15. **How many hot drinks do you have a day?**



Please write the amount in the box below

Hot or cold drinks



16. **What cold drink do you like to drink?**



○ **Squash**

Please tell us what you like to drink



○ **Fresh Juice**

Please tell us what you like to drink

17. **How many cold drinks do you have a day?**



Please write the amount in the box below

Hot or cold drinks



18.a. **Do you drink water?**

Yes ○ No ○

18.b. **If yes, how much do you drink a day?**



Please write the amount in the box below

Energy Drinks



19.a. **Do you drink energy drinks?**

Yes ○ No ○ Don't know ○



If you're not sure what an energy drink is, please ask.



19.b. **If yes, how many cans or bottles do you drink a week?**

_____ **Cans or bottles**



19.c. **Do you want help to drink less energy drinks?**

Yes ○ No ○

Fizzy Drinks



20.a. **Do you drink fizzy drinks?**

Yes ○ No ○ Don't know ○



If you're not sure what an fizzy drink is, please ask.



20.b. **If yes, how many cans or bottles do you drink a week?**

_____ **Cans or bottles**



20.c. **Do you want help to drink less fizzy drinks?**

Yes ○ No ○

Alcohol



21.a. **Do you drink alcohol?**

Yes ○ No ○

Examples of units in common alcoholic drinks



Pint of lager
2.6 units



175ml glass of wine
2.3 units



25ml of spirit
1 unit



275ml of alcopop
1.1 units



21.b. **If yes, how much do you drink each week?**

_____ units a week



21.c.. **Do you want help to drink less alcohol?**

Yes ○ No ○

My diet



22.a. **Do you have any difficulties eating, drinking or swallowing?**

Yes ○ **No** ○

22.b. **If yes, what helps you eat, drink or swallow?**





23. **Do you see a speech therapist about this difficulty?**

Yes ○ **No** ○



24. **Do you have any burning pain in your chest** (heartburn or indigestion)?

Yes ○ **No** ○

My diet

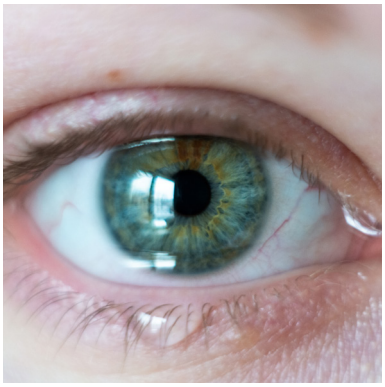


25. **What foods and drink do you like?**



26. **Do you cough when you eat?**

Yes ○ No ○



27. **Do your eyes water when you are eating?**

Yes ○ No ○



28. **Are you eating more or less than you used to?**

More ○ Less ○



29. **Do you see a dietician?**

Yes ○ No ○

Weight & appetite



30. **Are you worried about your weight** (either putting on too much weight or losing weight)?

Yes ○ No ○

Exercise



31. **What exercise do you do?**

Smoking



32.a. **Do you smoke**

Yes ○ No ○



32.b. **If yes, how many cigarettes do you smoke a day?**



33.a. **Do you vape**

Yes ○ No ○



33.b. **If you smoke or vape, would you like help to stop?**

Yes ○ No ○

My breathing



34. **Do you have any problems with your breathing?**

Yes ○ No ○



35.a. **Do you cough?**

Yes ○ No ○



35.b. **If yes, do you cough up anything?**

Yes ○ No ○



35.c. **If yes, what do you cough up? And how often?**

Medication



36. **Do you take any tablets or prescribed medication from your doctor?**

Yes ○ No ○



37. **Do you take any tablets or medicines that are not from your doctor** (things like vitamins, painkillers, laxatives)?

Yes ○ No ○

My allergies



38.a. **Do you have any allergies?**

Yes ○ No ○



38.b. **If yes, what are you allergic to?**

Drugs



39.a. **Do you use drugs** (for example cannabis or ecstasy)?

Yes ○ No ○



39.b.. **If yes, do you want help to stop using these drugs?**

Yes ○ No ○

Memory



40. **Do you or your carer think there has been a change in your memory?**

Yes ○ No ○

My eyesight



My vision

41. **Do you have any problems with your eyes or difficulty seeing things?**

Yes ○ No ○



42. **What was the date of your last optician's appointment** (if you are not sure, leave blank)?

DAY MONTH YEAR



42.a. **Do you need glasses?**

Yes ○ No ○



42.b. **If yes, do you wear your glasses?**

Yes ○ No ○

My eyesight



43. **Do you wear contact lenses?**

Yes ○ **No** ○

My hearing



44.a. **Do you have any difficulty hearing?**

Yes ○ No ○



44.b. **Do you have a hearing aid?**

Yes ○ No ○



44.c. **If yes, do you wear it?**

Yes ○ No ○



45.a. **Do you visit an audiologist** (someone who helps with hearing and balance problems)?

Yes ○ No ○



45.b. **If yes, what was the last date of your last appointment?**

DAY MONTH YEAR

My teeth



46.a. **Do you have any problems with your teeth, gums or mouth?**

Yes ○ **No** ○



46.b. **If yes, what?**



47. **Which dentist do you go to?**



48. **Do you go to the dentist regularly?**

Yes ○ **No** ○



49. **What was the date of your last dental appointment?**

DAY MONTH YEAR

My mobility



50. **Are you able to move around easily?**

Yes ○ No ○

51. **Any comments about your mobility**





52.a. **Do you have mobility aids** (these are things like a wheelchair, a stick or a frame)?

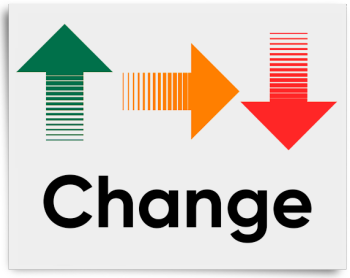
Yes ○ No ○



52.b. **If yes, what mobility aid(s) do you have?**

My mobility

52.c. **Do you still use them? Would you like a review?**



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



It's better ○



It's the same ○



It's worse ○

My mobility



54.a. **Do you see a physiotherapist** (physiotherapists work with people to help with a range of problems that affect your movement)?

Yes ○ No ○

54.b. **What was the date of your last review?**

DAY MONTH YEAR



55.a. **Do you see an occupational therapist** (occupational therapists help people of all ages to carry out everyday activities that are essential for health and wellbeing)?

Yes ○ No ○

55.b. **What was the date of your last review?**

DAY MONTH YEAR

My feet

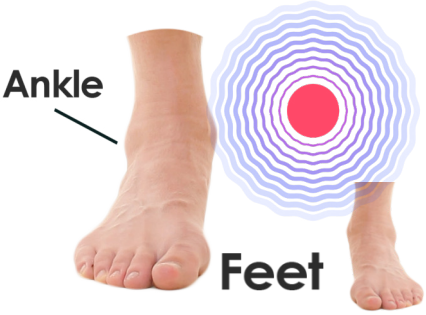


56.a. **Do you have any problems with your feet?**

Yes ○ No ○



56.b. **If yes, what?**



57. **Do you have swelling of your ankles or feet?**

Yes ○ No ○



58a. **Do you visit the podiatrist or chiropodist** (someone who can help with common foot problems)?

Yes ○ No ○



58.b. **If yes, what was the date of your last appointment?**

DAY MONTH YEAR



59. **Who cuts your toe nails?**

Hair, skin and nails



60.a. **Do you have any problems with your hair, skin or nails?**

Yes ○ No ○



60.b. **If yes, what?**

Sex



61. **Do you have sex?**

Yes ○ No ○



62. **Do you use contraceptives** (These are things that stop a women getting pregnant)?

Yes ○ No ○



63. **Have you had sexual health screening?**

Yes ○ No ○

My sleep



64. **Do you have problems sleeping?**

Yes ○ No ○



65. **What time do you go to bed?**



66. **What time do you wake up?**



67. **Does anyone tell you, you snore?**

Yes ○ No ○

Epilepsy



68.a. **Do you have epilepsy?**

Yes ○ No ○



68.b. **If yes, do you know what kind of epilepsy you have?**

Specialists



69. **Do you see a specialist doctor or nurse for your epilepsy?**

Yes ○ No ○



70. **In the last year, have you started to shake or have movements you cannot control?**

Yes ○ No ○

Epilepsy



71. **Have people noticed that sometimes you are not concentrating** (for example, having absences)?

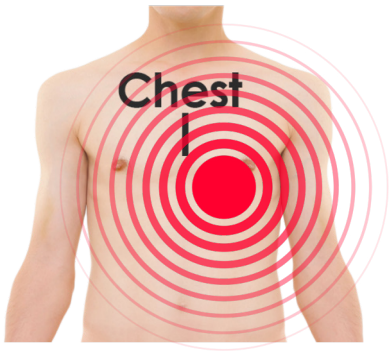
Yes ○ No ○

Pains



72. **How would someone know you are in pain?**

Pains

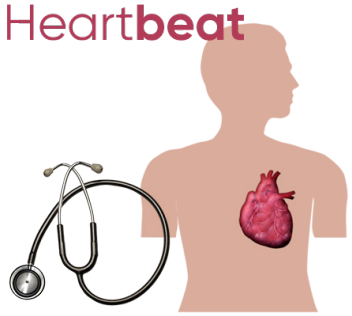


73.a. **Do you get any pain in your chest?**

Yes ○ No ○

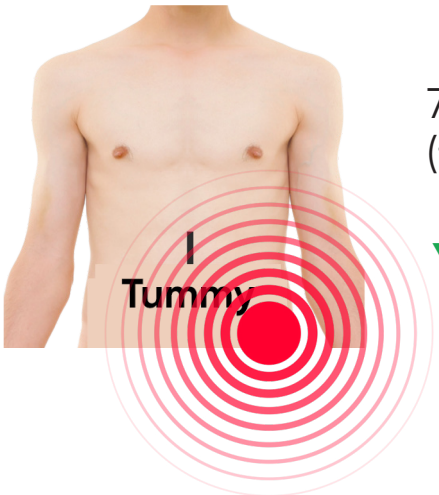


74.b. **If yes, when does the pain happen?**



75. **Do you feel you have an uneven heart beat or your heart beats fast?**

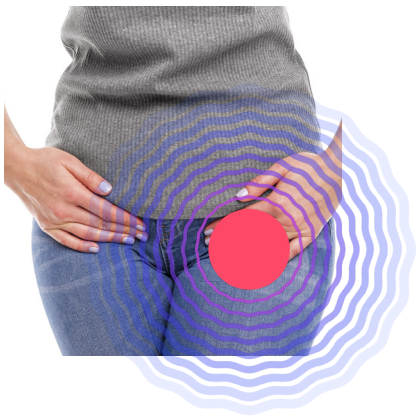
Yes ○ No ○



76. **Do you have any pain in your abdomen** (tummy)?

Yes ○ No ○

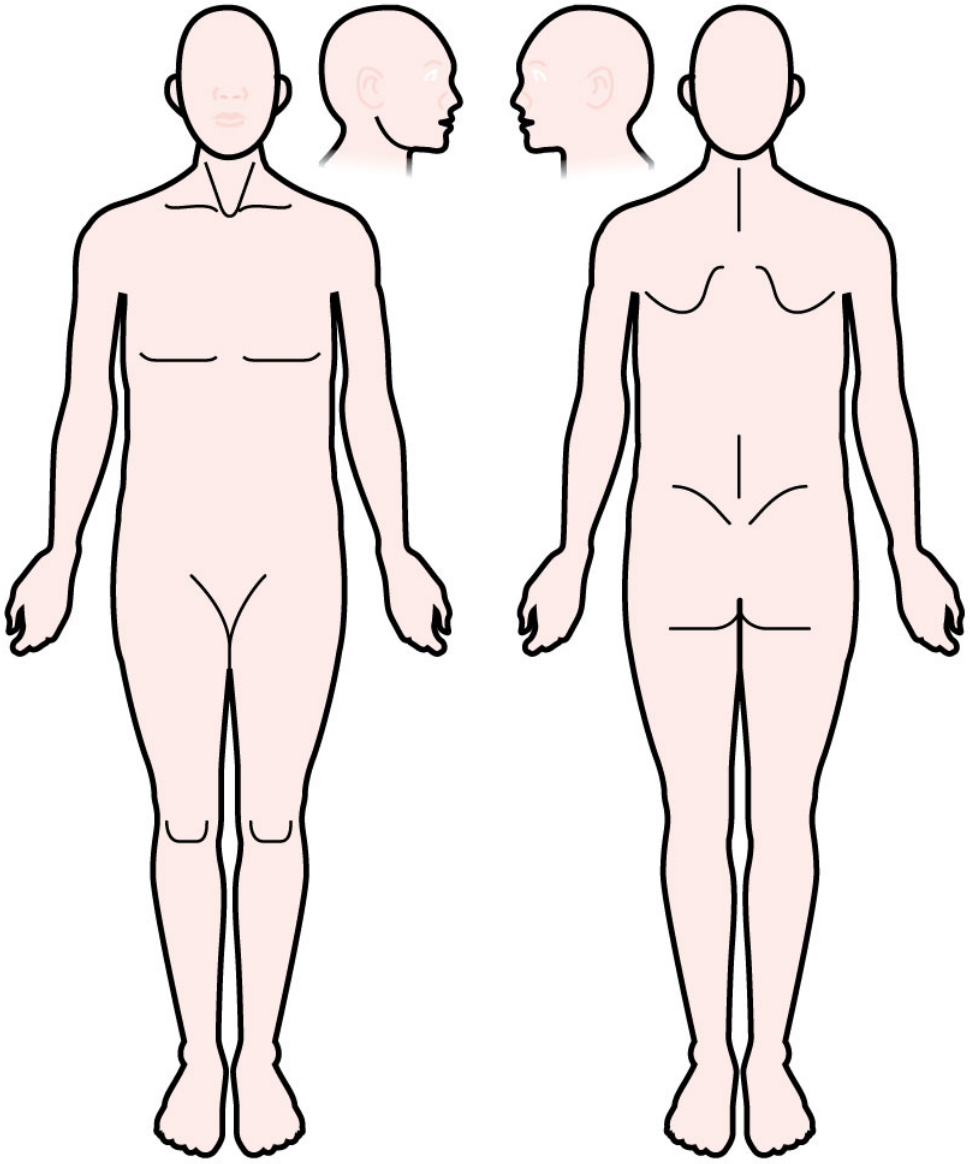
Pains



77. **Have you got any swellings in your groin** (just above the crease at the top of your leg)?

Yes ○ No ○

Please circle where your pain is on the body



Continence



78. **How many times a day do you have a poo?**



79. **What does your poo look like?**



○ **Type 1: Severe constipation**
Seperate, hard lumps



○ **Type 2: Mild constipation**
Lumpy and sausage like



○ **Type 3: Normal**
A sausage-shape with cracks in the surface



○ **Type 4: Normal**
Like a smooth, soft sausage or snake



○ **Type 5: Lacking fiber**
Soft blobs with clear-cut edges



○ **Type 6: Mild diarrhoea**
Mushy consistency with ragged edges



○ **Type 7: Severe diarrhoea**
Liquid consistency with no solid pieces

Continence



80. **Do you have any constipation or diarrhoea?**

Yes ○ No ○



81. **Do you have any problems pooing?**

For example, having an accident.

Yes ○ No ○

Poo



82. **Do you have any problems with weeing?**

For example, having an accident.

Yes ○ No ○

Wee



83. **Does it hurt / burn when you wee?**

Yes ○ No ○

Continence



Wee

84. **Do you have any other problems when you wee** (things like going to the toilet a lot)?



85. **What does your wee look like?**



○ **Type 1: Hydrated**



○ **Type 2: Ideal**



○ **Type 3: Good**



○ **Type 4: Fair**



○ **Type 5: Light dehydrated**



○ **Type 6: Dehydrated**



○ **Type 7: Very dehydrated**



○ **Type 7: Severe dehydrated**

Continence



86. **Is there any blood when you go to the toilet?**

Yes ○ No ○



87. **Do you see a continence nurse** (this is someone who can look at causes, create treatment plans and empower people who can't always control when they go to the toilet)?

Yes ○ No ○



88.a. **Do you have continence aids** (things like pads or medicine)?

Yes ○ No ○



88.b. **If yes, what?**

Any information you wish to share

89. **Do you have any other issues** (if you don't, leave the box blank)?

My Family



90.a. **Are there any medical problems or illnesses that run in your family?**

Yes ○ No ○



90.b. **If yes, what?**

My Mental Health



91. **Do you feel anxious or worried a lot of the time?**

Yes ○ No ○



92. **Do you feel sad for long periods of time and find it difficult to cheer yourself up?**

Yes ○ No ○



93. **Do you get angry and shout at people a lot?**

Yes ○ No ○



94. **Do you ever try to hurt yourself?**

Yes ○ No ○

My Mental Health



95. **Do you see a psychiatrist** (this is someone who specialises in the prevention, diagnosis, and treatment of mental illness)?

Yes ○ No ○



96. **Do you have support from the mental health team?**

Yes ○ No ○



97. **Do you have any other comments about your mental health?**

Screening



98.a. **Are you diabetic?**

Yes ○ No ○



98.b. **If your answer was yes, have you had your diabetic eye screening test?**

Yes ○ No ○



98.c. **If yes, when did you last do the test?**

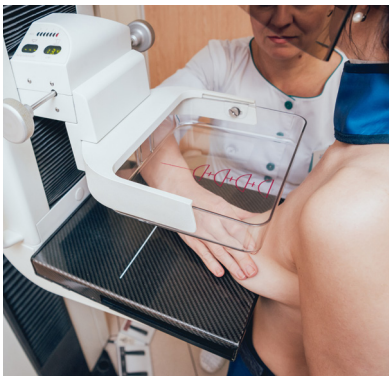
DAY MONTH YEAR

Screening



99.a. **Have you noticed any pain or lumps in your breasts?**

Yes ○ No ○



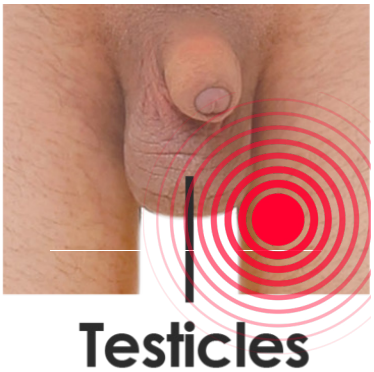
99.b. **Have you been for a breast screening test?**

Yes ○ No ○



99.c. **If yes, when was your last test?**

DAY MONTH YEAR



100. **Has there been any pain or swelling in your testicles?**

Yes ○ No ○

Screening



101. **Do you have any vaginal discharge that is smelly or makes you sore?**

Yes ○ No ○



102.a. **Have you had a cervical smear test?**

Yes ○ No ○





102.b. **If yes, when was your last test?**

DAY MONTH YEAR

If you are aged 60 – 69



103.a. **If you are aged between 60 – 69, have you been sent a kit to test for bowel cancer?**

Yes ○ **No** ○



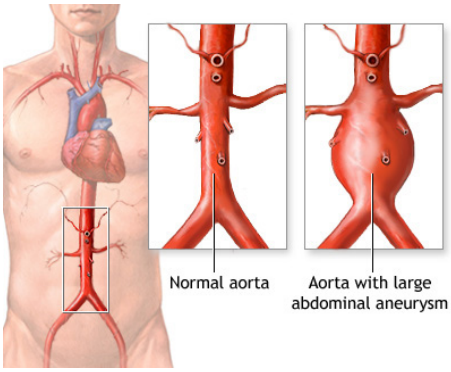
103.b. **If yes, when did you last do the test?**

DAY MONTH YEAR



104. **If you are 65 or over, have you been for an AAA (Abdominal Aortic Aneurysm) screening?**

Yes ○ **No** ○



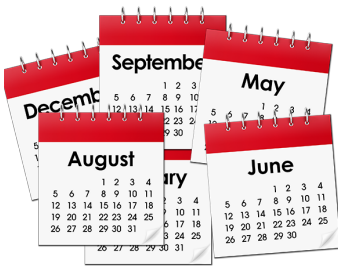
Abdominal Aortic Anesurysm: An abnormal bulging and weakening in your aorta as it goes through your tummy.

Periods



105. **Do you have periods?**

Yes ○ No ○



106. **Are your periods regular?**

Yes ○ No ○



107. **Are your periods painful?**

Yes ○ No ○



108. **Is the bleeding very heavy?**

Yes ○ No ○

Periods



109. **Have your periods changed?**

Yes ○ No ○



110. **Do you have any spotting or bleeding between periods?**
- for example bleeding between periods?

Yes ○ No ○

Menopause



111. **Have you had a discussion about the menopause with your nurse or doctor?**

Yes ○ No ○



112. **Would you like any more information about the menopause?**

Yes ○ No ○

My care and support



106. **If you have support, who supports you** (if you don't have any support, leave the boxes blank)?

Family



Name of family carer



Family carer's contact number



Family carer's e-mail address

Paid support worker / carer



Name of support worker or carer

My care and support

Paid support worker / carer



Support worker's phone number



Support worker's e-mail address

Social worker (if you have one)



Name of social worker



Social worker's contact number



Social worker's e-mail address

My care and support to others



107.a. **Are you a carer for anyone** (this could be for children, parents or a partner)?

Yes ○ No ○



107.b. **If yes, who do you care for?**

Hospital Passport



108. **Have you got a Hospital Passport?**
(Also known as, Health Passport, Communication Plan)

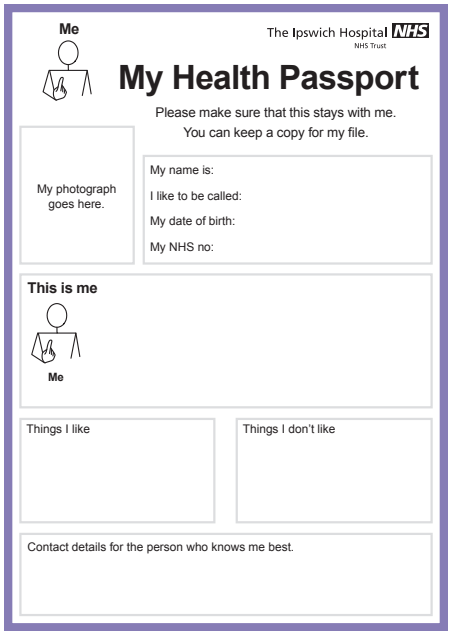
Yes ○ No ○



A form to provide healthcare professionals with information about you in an easy-to-understand way.

You can use this for hospital and GP appointments, with carers, dentists, opticians and many others.

Hospital Passport

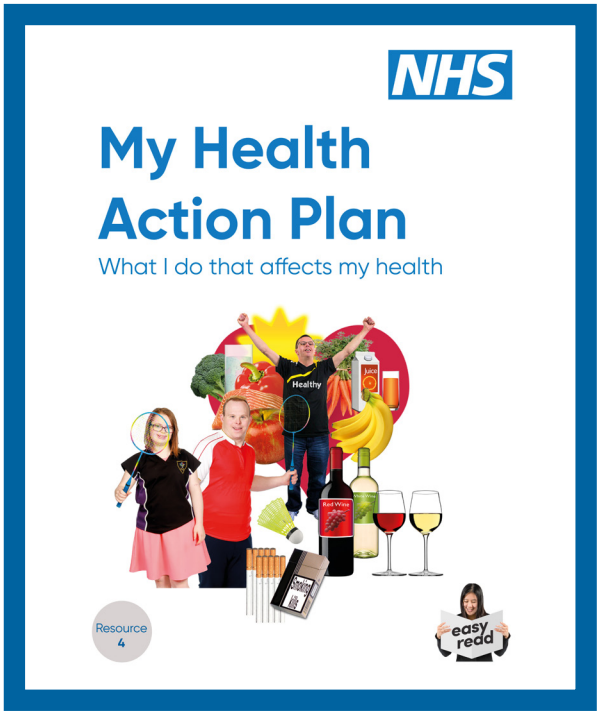


If you want or need an Ipswich Hospital Passport, you can download one here:
https://i3a5v6j6.stackpathcdn.com/wp-content/uploads/2019/04/Health-passport-2.pdf



If you want or need a Hospital Passport for West Suffolk, you can download one here:
https://www.wsh.nhs.uk/CMS-Documents/Health-passports/My-HealthPassport-WSH.pdf

Health Action Plan





109.a. **Have you been given a Health Action Plan?**

Yes ○ **No** ○



Health action plans are a record of a person's health, and also give information about what that person needs and wants to do to stay healthy.

If you would like a Health Action Plan you can download one here: https://suffolkordinarylives.co.uk/resources/my-health-action-plan/

Notes

Notes

Primary Care Accessible Resources

Resource 20: Pre-Health Check Questionnaire



This booklet was co-produced by Ace Anglia, Self-Advocates, Suffolk Learning Disability Liaison Nurses, GP Doctors.

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This booklet is **Resource 20** and forms part of a number of projects that help to explain things about primary care services.

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