Health Action Plan





Name:

Date of Birth:

Private

To be kept safe

My Health Plan

STOP – have you had an annual health check from your doctor or nurse? You should have one of these before starting to fill out this plan out.

STOP – you need to choose someone who will help you fill out this plan out and help you to keep it up to date and support you in taking action:

My Health Action Plan Supporter is:

Name:

Contact details:

You can use this plan to help you record information which is important and useful to you in managing your health and any long term conditions you may have.

What it might help others to know about me:

This section is for recording details of my personality, likes and dislikes to help inform health professionals and others about how I like to be treated.

Personal Information



Name:

I like to be known as:



Date of birth:



Address:



Telephone Number:



NHS Number:



Allergies:



Ethnic origin/
religion:



First language/how
I communicate:

The main person involved
in supporting me is:

Their telephone Number:

Other people who know me well:

GP (Doctor):

Address:

Telephone Number:

My Medication



Medication 	**What is the medication for?**	**Dose and Frequency** (How often do you take it?)	**When was this medication reviewed?**	**Date medication stopped**

Diary of Doctor Appointments



GP Name:

Address:

Telephone:

Date	Time	Reason for attending Why did you visit your GP?	Report / Outcome What happened? What issues were identified?
		MY ANNUAL HEALTH CHECK	

Diary of Dentist Appointments



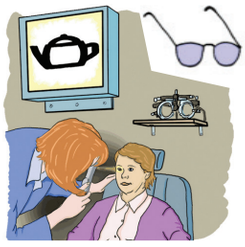
Dentist name:

Dentist address:

Dentist Telephone:

Date	Time	Reason for attending Why did you visit your Dentist?	Report / Outcome What happened? What issues were identified?

Diary of Eye Appointments



Optician name:

Optician address:

Optician Telephone:

Date	Time	Reason for attending Why did you visit your Optician?	Report / Outcome What happened? What issues were identified?

Diary of Hospital Appointments



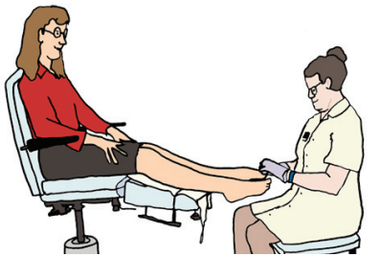
Consultant name:

Consultant address:

Consultant Telephone:

Date	Time	**Reason for attending** Why did you go to the hospital	**Report / Outcome** What happened? What issues were identified?

Diary of Health Appointments



Other Health Appointments

eg: Podiatry, Chiropody, Hospital Specialist, Psychology, Psychiatry.

Date	Time	Reason for attending Why did you visit?	Report / Outcome What happened? What issues were identified?

Diary of Health Appointments

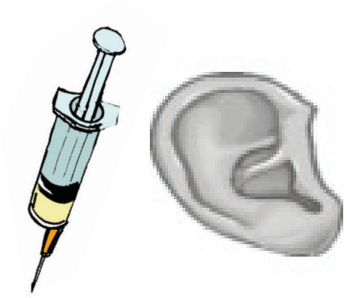


Blood Pressure, Pulse, Weight

Write in each time you have your Blood pressure, pulse or weight measured.

Date	Blood Pressure	Pulse	Weight

Diary of Health Appointments



Other Health Checks

eg: Blood tests, Hearing test, Breast check, Cervical Smear, Prostrate Checks, Testicular Checks

Date	Time	Reason for attending Why did you visit?	Report / Outcome What happened? What issues were identified?

Health Action Plan





When writing your Health Action Plan think about all the information before this page and:

Your eyes



Your ears



Your feet



Your teeth



Your weight



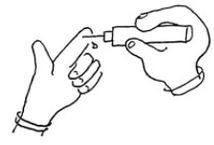
Going to the toilet



The food you eat



Diabetes



Epilepsy



Sexual Health



Mental Health



Health Action Plan





Name / describe the health issue:

To improve my health I want to achieve the following
OUTCOMES / GOALS:

1. _____
2. _____
3. _____

To achieve my goals I will take the following
ACTION

By When /
How Often?

1. _____ _____
2. _____ _____
3. _____ _____

To achieve my goals I will need the following
SUPPORT

By Whom /
How Often?

1. _____ _____
2. _____ _____
3. _____ _____

In order to check my progress we will
REVIEW

Location

Date of review _____ _____

Health Action Plan





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Health Action Plan





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Location

Date of review _____ _____

SUMMARY: My Health Issues/ Long Term Conditions are:









Name of the Condition e.g. Epilepsy, diabetes, Mental health, Sickle Cell Anaemia, Asthma	How does this effect me?	What is my number one Goal ?	What is the first action I have agreed to take?
1.			
2.			
3.			
4.			
5.			
6.			

THIS PLAN WILL BE REVIEWED AT LEAST ANNUALLY

Date: _____ **Location:** _____

Any Other Information

Any Other Information

Developed in partnership by
NHS South West Essex and Essex County Council

NHS
South West Essex

Essex County Council