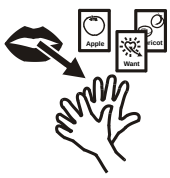
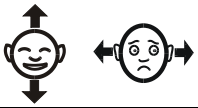
Health Check for People with a Learning Disability

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)	

	**Do you have a Health Action Plan?** Yes ☐ No ☐ If so, please fill it out and bring it with you to your appointment.
	**I communicate by…** (tick as many as you like)
	 Talking ☐
	 Signing ☐
	 Using a communication aid ☐
	 Pointing ☐
	 Using gestures (nodding, raising eyebrows) ☐

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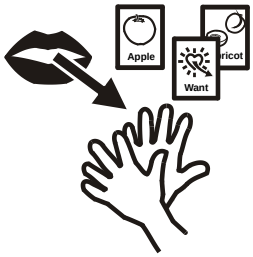
	**The language I speak and understand best is...**	
	**Do have any difficulty in communicating?** Yes ☐ No ☐ **If you do, what help do you need to communicate?**	
	**Ethnicity**	
	**Religion**	
	**Do you have a job**	Yes ☐ No ☐
	**What job do you do?**	
	**Who looks after you? Tell us the names of all the people who look after you.**	
		**Family carer:**
		**Paid carer:**

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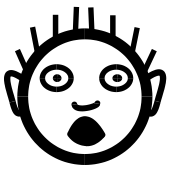
		**Healthcare worker:**
		**Social care worker:**
	**Are you a carer for anyone? (children, parents or partner)**	Yes ☐ No ☐
	**Please tell us about where you live.** **What kind of place is it?** For example: • Your family home • Your own flat • A residential care home • Supported living	
	**Do you have any allergies?**	
	**Do you have any medical fears/phobias?**	
	**How would someone know if you were in pain?**	

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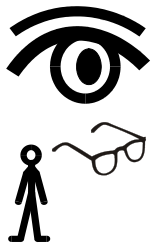
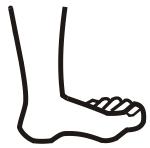
	**Do you have any problems with your eyes and seeing things?** **What was the date of your last optician's appointment?**	Yes ☐ No ☐
	**Do you have any difficulty hearing?**	Yes ☐ No ☐
 	**Do you have a hearing aid?** **Do you wear it?** **Do you visit an audiologist?** **Date of your last appointment?**	Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐
	**Do you have any problems with your teeth or mouth?** **If so, what?**	Yes ☐ No ☐
	**Do you visit the dentist regularly?** **Date of last appointment?**	Yes ☐ No ☐
	**Do you have any problems with your feet?** **If so, what?**	Yes ☐ No ☐

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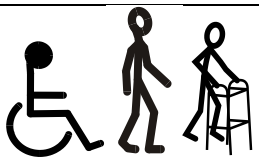
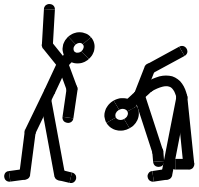
	**Do you visit the podiatrist/ chiropodist?** Yes ☐ No ☐ **Date of last appointment?**
	**Are you able to move around easily?** Yes ☐ No ☐ **Do you use mobility aids?** *(a wheelchair, stick or frame)* **If so, what?** **Has your mobility changed in the last year?** It's worse ☐ It's the same ☐ It's better ☐
	**Do you see a physiotherapist?** Yes ☐ No ☐
	**Do you see an Occupational Therapist?** Yes ☐ No ☐
	**What exercise do you do?**
	**Do you drink alcohol?** Yes ☐ No ☐ **How many units* do you drink a week?** **(*A unit is half a pint of beer or a small glass of wine or a single shot of spirits)** _____Units **Do you want help to drink less alcohol?** Yes ☐ No ☐

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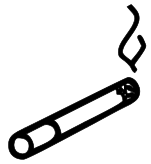
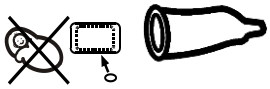
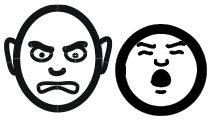
	**Do you smoke?**	Yes ☐ No ☐
	How many cigarettes a day?	_____
	Would you like help to stop smoking?	Yes ☐ No ☐
	**Do you take any tablets or medicines that are not from your doctor? E.g. vitamins, painkillers, laxatives**	Yes ☐ No ☐
	**Do you use any drugs like cannabis, ecstasy etc**	Yes ☐ No ☐
	If Yes, do you want help to stop using these drugs?	Yes ☐ No ☐
	**Do you have sex?**	Yes ☐ No ☐
	**Do you use contraceptives?**	Yes ☐ No ☐
	**Do you have problems sleeping?**	Yes ☐ No ☐
	**Do you ever try to hurt yourself?**	Yes ☐ No ☐
	**Do you get angry and shout at people a lot?**	Yes ☐ No ☐
	**Has your appetite changed recently?**	Yes ☐ No ☐

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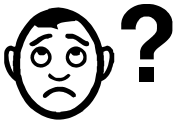
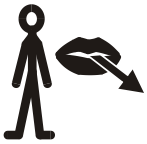
	**Do you feel anxious and worried a lot of the time?**	Yes ☐ No ☐
	**Do you feel sad for long periods of time and find it difficult to cheer yourself up?**	Yes ☐ No ☐
	**Do you or your carer think there has been a change in your memory?**	Yes ☐ No ☐
	**Do you see a psychologist?**	Yes ☐ No ☐
	**Are you worried about your weight?** *(either putting on too much weight or losing weight)*	Yes ☐ No ☐
	**Do you have any difficulties eating and drinking?** **If Yes, what help do you need with eating and drinking?** **Do you have any problems with swallowing?** **Do you have any burning pain in the centre of your chest?** *("heartburn" or indigestion)*	Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐
	**Do you see a speech therapist to help you with eating, drinking or communication?**	Yes ☐ No ☐
	**Do you see a Dietician?**	Yes ☐ No ☐

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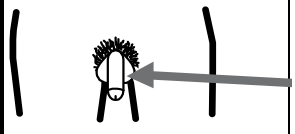
Do you have constipation or diarrhoea?	Yes ☐ No ☐
Does it hurt when you wee?	Yes ☐ No ☐
Is there any blood in your wee?	Yes ☐ No ☐
Do you have any other problems when you wee?	Yes ☐ No ☐
Do you have any problems with urinary (wee) incontinence?	Yes ☐ No ☐
Do you have any problems with faecal (poo) incontinence?	Yes ☐ No ☐
Do you see a continence nurse?	Yes ☐ No ☐
Do you have continence aids or medicine? **If so, what?**	Yes ☐ No ☐

MEN AND WOMEN AGED 60 - 69:

If you are aged between 60 and 69, have you been sent a kit to test for bowel cancer?	Yes ☐ No ☐
When did you last do the test?	

FOR MEN:



Has there been any pain or swelling in your testicles?	Yes ☐ No ☐

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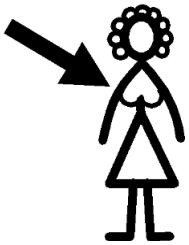
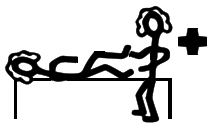
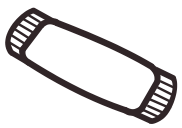
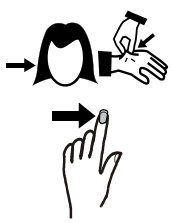
FOR WOMEN:		
	**Have you noticed any pain or lumps in your breasts?**	Yes ☐ No ☐
	If you are over 50, have you been for a breast screening test?	Yes ☐ No ☐
	When was your last test?	
	**If you are aged 25 to 64, have you had a cervical smear test?**	Yes ☐ No ☐
	When was your last test?	
	**Do you have 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?** *(for example, between periods)*	Yes ☐ No ☐
	Do you have any vaginal discharge that is smelly or makes you sore?	Yes ☐ No ☐

	**Do you have any problems with your hair, skin or nails?** **If so, what?**	Yes ☐ No ☐

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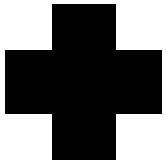
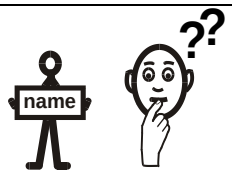
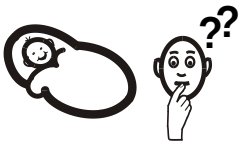
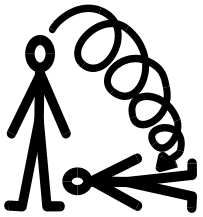
	**Are there any medical problems or illnesses that run in your family?**
	**Do other people in your family have a learning disability?** Yes ☐ No ☐
	**Do you have any other health conditions?**
	**Does your kind of learning disability have a name?**
	**Were you born with the learning disability or did something cause it?**
	**Do you see a psychiatrist?** Yes ☐ No ☐
	**Do you have epilepsy?** Yes ☐ No ☐ **Do you know what kind of epilepsy you have?** **In the last year have you started to shake or have movements that you cannot control?** Yes ☐ No ☐

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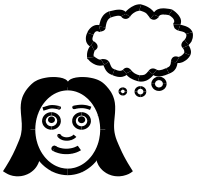
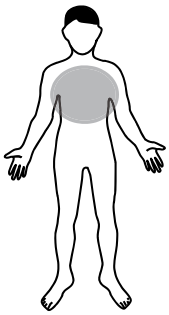
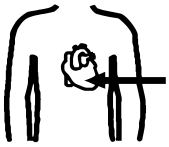
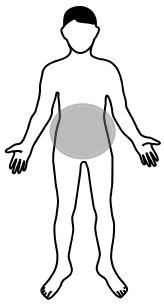
	**Has your carer noticed that sometimes you are not concentrating?** *(e.g. seem to have absences)*	Yes ☐ No ☐
	**Do you see a specialist doctor or nurse about your epilepsy?**	Yes ☐ No ☐
	**Do you get any pain in your chest?** **When does the chest pain happen?**	Yes ☐ No ☐
	**Do you have any swelling of your ankles or feet?**	Yes ☐ No ☐
	**Do you feel you have an uneven heart beat or your heart beating fast?**	Yes ☐ No ☐
	**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)	Yes ☐ No ☐
	**Do you have any problems with your breathing?**	Yes ☐ No ☐
	**Do you cough?**	Yes ☐ No ☐
	Do you cough up anything?	Yes ☐ No ☐

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