
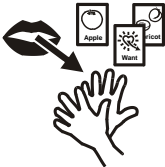




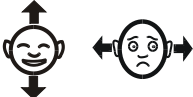




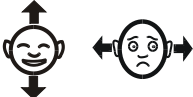




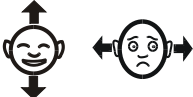



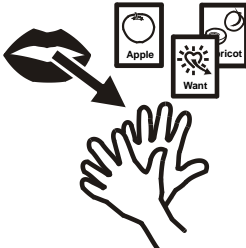







## Health Check for People with a Learning Disability



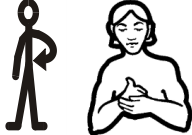




Please fill in these pages with the help of your carer (if you have one) before you come and visit the doctor.

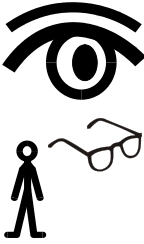


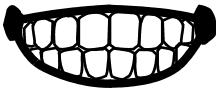


Please bring with you all your **medicines** whether prescribed by the doctor or not, your **health action plan** if you have one and a **urine sample** in a small bottle.


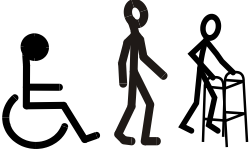


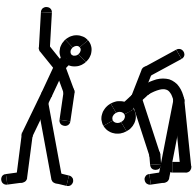

Date of health check	
Name	
Date of Birth	
Male / Female	
Address	
Main Carer	
Key social care contact (name and contact details)	

	<p><b>Do you have a Health Action Plan?</b>      Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>If so, please fill it out and bring it with you to your appointment.</p>															
	<p><b>I communicate by...</b>      (tick as many as you like)</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="text-align: center; width: 10%;"></td> <td style="padding: 5px;">Talking</td> <td style="text-align: right; width: 10%;"><input type="checkbox"/></td> </tr> <tr> <td style="text-align: center;"></td> <td style="padding: 5px;">Signing</td> <td style="text-align: right;"><input type="checkbox"/></td> </tr> <tr> <td style="text-align: center;"></td> <td style="padding: 5px;">Using a communication aid</td> <td style="text-align: right;"><input type="checkbox"/></td> </tr> <tr> <td style="text-align: center;"></td> <td style="padding: 5px;">Pointing</td> <td style="text-align: right;"><input type="checkbox"/></td> </tr> <tr> <td style="text-align: center;"></td> <td style="padding: 5px;">Using gestures (nodding, raising eyebrows)</td> <td style="text-align: right;"><input type="checkbox"/></td> </tr> </table>		Talking	<input type="checkbox"/>		Signing	<input type="checkbox"/>		Using a communication aid	<input type="checkbox"/>		Pointing	<input type="checkbox"/>		Using gestures (nodding, raising eyebrows)	<input type="checkbox"/>
	Talking	<input type="checkbox"/>														
	Signing	<input type="checkbox"/>														
	Using a communication aid	<input type="checkbox"/>														
	Pointing	<input type="checkbox"/>														
	Using gestures (nodding, raising eyebrows)	<input type="checkbox"/>														









 <p>English      英語      हिन्दी      العربية      粵語</p>	<p>The language I speak and understand best is...</p>	
	<p>Do have any difficulty in communicating? <span style="float: right;">Yes <input type="checkbox"/> No <input type="checkbox"/></span>          If you do, what help do you need to communicate?</p>	
	<p>Ethnicity</p>	
	<p>Religion</p>	
	<p>Do you have a job</p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>
	<p>What job do you do?</p>	
	<p>Who looks after you? Tell us the names of all the people who look after you.</p>	
		<p>Family carer:</p>
	<p>Paid carer:</p>	

		<b>Healthcare worker:</b>
		<b>Social care worker:</b>
	<b>Are you a carer for anyone? (children, parents or partner)</b>	Yes <input type="checkbox"/> No <input type="checkbox"/>
	<b>Please tell us about where you live. What kind of place is it?</b>  For example: <ul style="list-style-type: none"> <li>• Your family home</li> <li>• Your own flat</li> <li>• A residential care home</li> <li>• Supported living</li> </ul>	
	<b>Do you have any allergies?</b>	
	<b>Do you have any medical fears/phobias?</b>	
	<b>How would someone know if you were in pain?</b>	

	<p><b>Do you have any problems with your eyes and seeing things?</b> Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p><b>What was the date of your last optician's appointment?</b></p>
	<p><b>Do you have any difficulty hearing?</b> Yes <input type="checkbox"/> No <input type="checkbox"/></p>
	<p><b>Do you have a hearing aid?</b> Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p><b>Do you wear it?</b> Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p><b>Do you visit an audiologist?</b> Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p><b>Date of your last appointment?</b></p>
	<p><b>Do you have any problems with your teeth or mouth?</b> Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p><b>If so, what?</b></p>
	<p><b>Do you visit the dentist regularly?</b> Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p><b>Date of last appointment?</b></p>
	<p><b>Do you have any problems with your feet?</b> Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p><b>If so, what?</b></p>

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

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

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



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? Yes  No

If so, what?

### MEN AND WOMEN AGED 60 - 69:

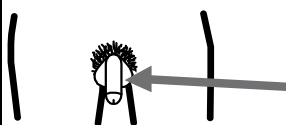


If you are aged between 60 and 69, have you been sent a kit to test for bowel cancer? Yes  No



When did you last do the test?

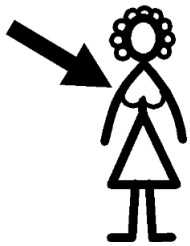
### FOR MEN:



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



**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?**

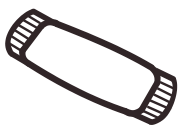
Yes  No

**Are your periods painful?**

Yes  No

**Is the bleeding very heavy?**

Yes  No

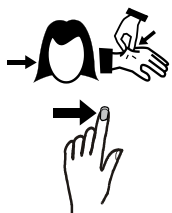


**Is there any irregular bleeding?**  
*(for example, between periods)*

Yes  No

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



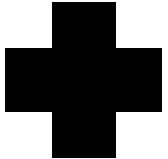
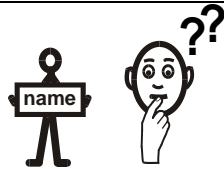



Yes  No

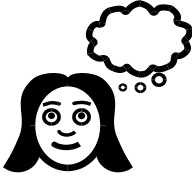

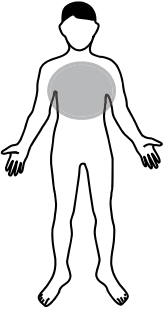

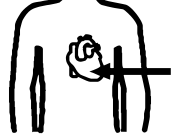
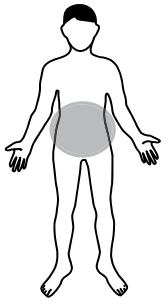

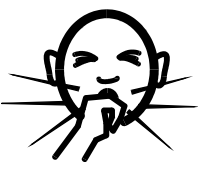


**Do you have any problems with your hair, skin or nails?**

Yes  No

**If so, what?**

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

	<p><b>Has your carer noticed that sometimes you are not concentrating?</b> (e.g. seem to have absences)</p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>
	<p><b>Do you see a specialist doctor or nurse about your epilepsy?</b></p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>
	<p><b>Do you get any pain in your chest?</b> <b>When does the chest pain happen?</b></p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>
	<p><b>Do you have any swelling of your ankles or feet?</b></p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>
	<p><b>Do you feel you have an uneven heart beat or your heart beating fast?</b></p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>
	<p><b>Do you have any pain in your abdomen?</b></p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>
	<p><b>Have you got any swellings in your groin? (just above the crease at the top of your legs)</b></p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>
 	<p><b>Do you have any problems with your breathing?</b></p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>
	<p><b>Do you cough?</b></p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>
	<p><b>Do you cough up anything?</b></p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>

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