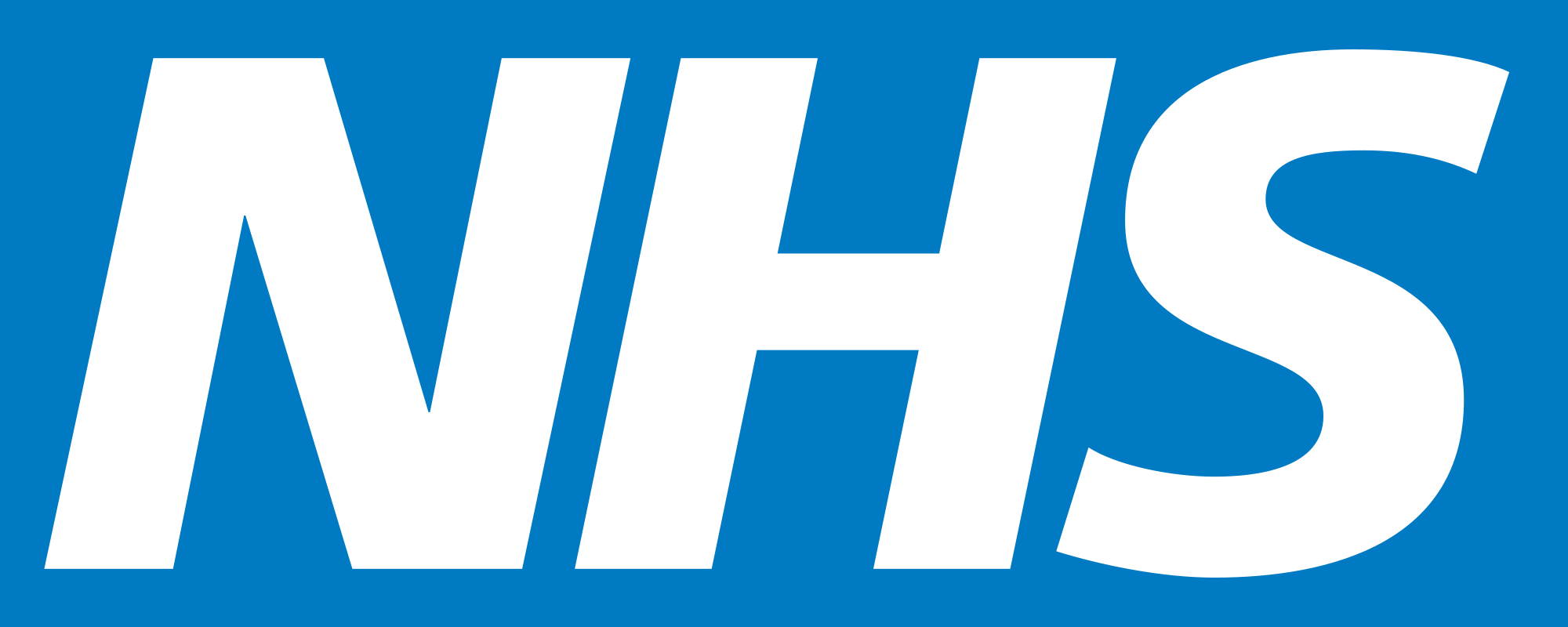
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| **NHS Number / Patient Reference:** |  |
| **Issue Date:** |  |

Annual Health Checks for People Aged 14+ with a Learning Disability in Manchester

**‘My Health’ Checklist**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Eyes / Vision**  Please tick ‘Yes’ or ‘No’ | | | **YES** | **NO** |
| Do you have any eyesight problems or wear glasses or contact lenses? | | |  |  |
| Have you noticed any recent problems or changes to your eyesight? | | |  |  |
| Have you visited an optician to have your eyes tested? | | |  |  |
| If yes, when was this? | |  | | |
| **Comments** |  | | | |

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| --- | --- | --- | --- | --- |
| **Hearing**  Please tick ‘Yes’ or ‘No’ | | | **YES** | **NO** |
| Do you have any hearing problems or have a hearing aid or hearing implant? | | |  |  |
| Have you noticed any recent problems or changes to your hearing? | | |  |  |
| Have you visited a hearing clinic (audiologist) / had your hearing tested? | | |  |  |
| If yes, when was this? | |  | | |
| **Comments** |  | | | |

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| --- | --- | --- | --- | --- | --- |
| **Skin** | | | Please tick ‘Yes’ or ‘No’ | **YES** | **NO** |
| Have you recently experienced: | | | |
| Dry or itchy skin? | | | |  |  |
| Warts? | | | |  |  |
| Sores or open wounds? | | | |  |  |
| Cold sores? | | | |  |  |
| Pressure sores or areas of concern on your skin? | | | |  |  |
| A skin problem you have been prescribed medication for? | | | |  |  |
| If yes, what medication? | |  | | | |
| **Comments** |  | | | | |

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| --- | --- | --- | --- | --- |
| **Teeth / Mouth**  Please tick ‘Yes’ or ‘No’ | | | **YES** | **NO** |
| Have you had tooth pain recently? | | |  |  |
| Do your gums bleed? | | |  |  |
| Do you have a swelling or a lump in your mouth? | | |  |  |
| Do you have difficulty eating because of a problem with your teeth or your mouth? | | |  |  |
| Do you have a dentist? | | |  |  |
| If yes, when did you last visit the dentist? | |  | | |
| **Comments** |  | | | |

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| **Eating and Drinking**  Please tick ‘Yes’ or ‘No’ | | **YES** | **NO** |
| Does eating make you feel unwell? | |  |  |
| Have you recently experienced being sick during or soon after eating? | |  |  |
| Have you experienced any recent changes to your appetite? | |  |  |
| Do you experience difficulty swallowing? | |  |  |
| Have you recently experienced coughing when eating or drinking? | |  |  |
| Do you eat things that are not food? | |  |  |
| Do you use any supplements, for example, multi vitamins, fish oils, Complan? | |  |  |
| Do you have food allergies or intolerances? | |  |  |
| If yes, please tell us what they are: |  | | |
| **Comments** |  | | |

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| **Weight**  Please tick ‘Yes’ or ‘No’ | | **YES** | **NO** |
| Do you or people you know have any concerns about your weight? (If yes, please tell us below) | |  |  |
| Do you need specialist equipment to weigh you? | |  |  |
| Has your weight changed in the last 3 – 6 months? | |  |  |
| If yes, please tell us how it has changed: |  | | |
| **Comments** |  | | |
| **If you or a carer have any concerns about your weight, please bring your weight chart with you to your appointment.** | | | |

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| --- | --- | --- | --- | --- |
| **Diabetes**  Please tick ‘Yes’ or ‘No’ | | | **YES** | **NO** |
| Do you have diabetes? | | |  |  |
| If yes, what type and how long have you had diabetes? | |  | | |
| If you have diabetes, do you test your blood sugar regularly? | | |  |  |
| If you have diabetes, do you also have any problems with your eye-sight? | | |  |  |
| Have you been for your diabetic eye screening? | | |  |  |
| If yes, when was this? |  | | | |
| **If you have blood sugar charts please bring them to your appointment.** | | | | |
| For easy read information on diabetic eye screening, please scan the QR code or search: | | | INSERT QR HERE | |
| |  | | --- | | ‘diabetic eye screening easy read uk’ | | | |  | |

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| **Mobility**  Please tick ‘Yes’ or ‘No’  Have you recently experienced: | | **YES** | **NO** |
| Stiffness or difficulty moving? | |  |  |
| Slowing of movements? | |  |  |
| Pain when moving? | |  |  |
| Repeated falling or tripping? | |  |  |
| Changes in posture or mobility? | |  |  |
| The need to use mobility equipment? | |  |  |
| Swelling or redness in your limbs or skin? | |  |  |
| **Comments** |  | | |

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| --- | --- | --- | --- | --- |
| **Feet**  Please tick ‘Yes’ or ‘No’ | | | **YES** | **NO** |
| Have you recently experienced regular pain in your feet? If yes, please provide details below. | | |  |  |
| Have you been to a podiatrist (foot specialist)? | | |  |  |
| If yes, when did you last go? | |  | | |
| If no, who cuts your toenails? | |  | | |
| **Comments** |  | | | |

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| --- | --- | --- | --- | --- |
| **Pain**  Please tick ‘Yes’ or ‘No’ | | | **YES** | **NO** |
| Have you recently experienced regular pain in your body? If yes, please provide details below. | | |  |  |
| Have you been taking medication to manage pain? | | |  |  |
| If yes, what medication and how often? | |  | | |
| If you have been taking pain relief medication, has it helped to stop or reduce pain? | | |  |  |
| **Comments** |  | | | |

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| **Heart**  Please tick ‘Yes’ or ‘No’ | | **YES** | **NO** |
| Have you recently experienced: | |
| Difficulty breathing during the day or at night? | |  |  |
| Chest pain, including when exercising? | |  |  |
| Feeling like your heart is beating irregularly or very fast, or like it is ‘pounding’, ‘thumping’ or ‘fluttering’) | |  |  |
| Any swelling in your ankles, hands or elsewhere in your body? | |  |  |
| **Comments** |  | | |

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| --- | --- | --- | --- | --- | --- |
| **Brain**  Please tick ‘Yes’ or ‘No’ | | | | **YES** | **NO** |
| Have you recently experienced: | | | |
| Fainting (temporary loss of consciousness)? | | | |  |  |
| Blackouts (temporary loss of memory)? | | | |  |  |
| ‘Pins and needles’, ‘tingling’ or prickling sensations? | | | |  |  |
| Weakness in your arms or legs? | | | |  |  |
| Have you had a stroke? | | | |  |  |
| If yes, when did this happen? | |  | | | |
| Do you have epilepsy? | | | |  |  |
| If yes, approximately how many seizures do you have per month? | | |  | | |
| If you have epilepsy, are you under the care of an epilepsy specialist (neurologist)? | | | |  |  |
| If yes, when did you last see them? | | |  | | |
| Do you have known triggers for epileptic seizures, for example, flashing lights, TV, tiredness, infections? | | | |  |  |
| Do you take your epilepsy medication regularly and as prescribed? | | | |  |  |
| Do you experience any side effects of your epilepsy medication, for example, dizziness, feeling sick, blurred vision, feeling irritable? | | | |  |  |
| **Comments** |  | | | | |
| **If you have a seizure chart, please bring it to your appointment.** | | | | | |

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| **Lungs / Breathing**  Please tick ‘Yes’ or ‘No’ | | **YES** | **NO** |
| Have you recently experienced: | |
| Coughing that won’t go away (for longer than 3 weeks)? | |  |  |
| A chest infection? | |  |  |
| Coughing up blood? | |  |  |
| Unusual coloured spit? | |  |  |
| Wheezing? | |  |  |
| Breathlessness? | |  |  |
| Hay fever, allergies, asthma or chronic obstructive pulmonary disease (COPD)? | |  |  |
| Do you smoke or vape? If yes, please tell us how much / how often you do so below. | |  |  |
| **Comments** |  | | |

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| --- | --- | --- | --- | --- |
| **Flu**  Please tick ‘Yes’ or ‘No’ | | **YES** | | **NO** |
| Have you had your nasal spray or flu vaccine injection? | |  | |  |
| **Comments** |  | | | |
| For easy read information about the flu, please scan the QR code or search: | | | INSERT QR HERE | |
| |  | | --- | | ‘flu leaflet easy read uk’ | | | |  | |

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| **Mental Health**  Please tick ‘Yes’ or ‘No’  Have you recently experienced: | | | **YES** | **NO** |
| Being more forgetful or confused, or feeling worried about forgetting or feeling confused more often? | | |  |  |
| Feeling low, sad, unhappy or feeling like crying? | | |  |  |
| Feeling worried, frightened or anxious? | | |  |  |
| Feeling like you can’t cope or look after yourself? | | |  |  |
| Wanting to hurt yourself? | | |  |  |
| Feeling irritable, aggressive or wanting to hurt someone else? | | |  |  |
| Hearing voices or seeing things that are not there? | | |  |  |
| If ‘yes’ to any of the above, have you spoken to someone about it? | | |  |  |
| If yes, who have you spoken to? | |  | | |
| Have you requested or are you receiving help from a mental health professional or service? | | |  |  |
| If yes, please provide details: | |  | | |
| Are you taking any medication for your mental health? | | |  |  |
| If yes, please provide details: | |  | | |
| **Comments** |  | | | |

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| --- | --- | --- | --- | --- | --- |
| **Health Screening - Women**  Please tick ‘Yes’ or ‘No’ | | | **YES** | | **NO** |
| Have you had a smear test (cervical screening)? | | |  | |  |
| If yes, when was this? | |  | | | |
| Have you experienced a change in periods, for example, heavy bleeding between periods, painful periods, vaginal discharge? | | |  | |  |
| If you are aged 50+, have you had a mammogram (breast screening)? | | |  | |  |
| If yes, when was this? | |  | | | |
| **Comments** |  | | | | |
| For easy read information about cervical screening, please scan the QR code or search: | | | | INSERT QR HERE | |
| |  | | --- | | ‘cervical screening easy read uk’ | | | | |  | |

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| For easy read information about breastl screening, please scan the QR code or search: | INSERT QR HERE |
| |  | | --- | | ‘breast screening easy read uk’ | |  |

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| --- | --- | --- | --- | --- |
| Breasts | | Please tick ‘Yes’ or ‘No’  Have you recently experienced: | **YES** | **NO** |
| Any lumps in your breasts or armpits? | | |  |  |
| Any liquid from your nipples? | | |  |  |
| Any changes in the shape of your breasts? | | |  |  |
| Any changes to the skin on your breasts? | | |  |  |
| Any changes to shape of your nipples? | | |  |  |
| Any change in colour to your breasts or nipples? | | |  |  |
| **Comments** |  | | | |

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| --- | --- | --- | --- | --- |
| Menopausal Symptoms | | Please tick ‘Yes’ or ‘No’ | **YES** | **NO** |
| Have you recently experienced: | | |
| Feeling more tired than usual? | | |  |  |
| Being more forgetful than usual or having more ‘brain fog’? | | |  |  |
| Sudden changes in mood or having ‘mood swings’? | | |  |  |
| Feeling more sad than usual? | | |  |  |
| Feeling more anxious than usual? | | |  |  |
| Feeling more irritable or annoyed than usual? | | |  |  |
| ‘Hot flushes’ (a sudden feeling of heat and sometimes a red, flushed face and sweating)? | | |  |  |
| **Comments** |  | | | |

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| **Sexual Health**  Please tick ‘Yes’ or ‘No’ | | **YES** | | **NO** |
| Are you sexually active? | |  | |  |
| If yes, do you use any contraception? | |  | |  |
| Do you have any questions or concerns about your sexual health, including contraception or sexually transmitted infections? | |  | |  |
| **Comments** |  | | | |
| For easy read information about sexual health, please scan the QR code or search: | | | INSERT QR HERE | |
| |  | | --- | | ‘lets talk about it easy read nhs’ | | | |  | |

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| --- | --- | --- | --- |
| Urine  Please tick ‘Yes’ or ‘No’ | | **YES** | **NO** |
| Have you recently experienced: | |
| Pain when you urinate? | |  |  |
| Incontinence or getting to the toilet in time? | |  |  |
| A urinary infection? | |  |  |
| Urinating more often? | |  |  |
| Finding it difficult to start urinating? | |  |  |
| Your urine stopping and starting when you urinate? | |  |  |
| Blood in your urine? | |  |  |
|  | | | |
| If you are aged 60-74, have you received your bowel screening kit? | |  |  |
| **Comments** |  | | |

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| --- | --- | --- | --- | --- |
| Bowels  Please tick ‘Yes’ or ‘No’ | | **YES** | | **NO** |
| Have you recently experienced: | |
| Constipation, hard stools or being unable to pass stools? | |  | |  |
| Diarrhoea, watery stools, passing stools a lot more often or difficulty getting to the toilet in time? | |  | |  |
| Stomach cramps, bloating, or feeling more tired or weak than usual? | |  | |  |
| Blood in your stools or rectal bleeding (bleeding from your bottom)? | |  | |  |
| Significant changes in your bowel pattern? | |  | |  |
|  | | | | |
| If you are aged 60-74, have you received your bowel screening kit? | |  | |  |
| **Comments** |  | | | |
| For easy read information about bowel cancer screening please scan the QR code or search: | | | INSERT QR HERE | |
| |  | | --- | | ‘bowel cancer screening easy read uk’ | | | |  | |

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| **Medication**  Please tick ‘Yes’ or ‘No’ | | | **YES** | **NO** |
| Can you swallow a tablet? | | |  |  |
| Do you need liquid medication? | | |  |  |
| Do you have any questions or concerns about any current medication you are taking? | | |  |  |
| Please bring a list of your current medication to your appointment or tell us about any current medication in the space below. | | | | |
| **Medication** | | **How I take my Medication** | | |
|  | |  | | |
| **Comments** |  | | | |

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| null**Hospital Passport\***  Please tick ‘Yes’ or ‘No’ | | | **YES** | | **NO** |
| Do you have a hospital passport? | | |  | |  |
| If yes, when was it last updated? | |  | | | |
| If you do not have a hospital passport, would you like help to make one? | | |  | |  |
| **Comments** |  | | | | |
| \*A hospital passport is a document about you and your health needs. You can also add information about your interests, likes, dislikes, how you communicate and any reasonable adjustments that you might need. | | | | | |
| For easy read information about hospital passports, please scan the QR code or search: | | | | INSERT QR HERE | |
| |  | | --- | | ‘hospital passport easy read’ | | | | |  | |

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| --- | --- |
|  | Thank you for completing this form.  Please remember to return it to your GP Practice before your Annual Health Check or bring it with you to your appointment along with any other important information. |