


# My Pre-Health Check Questionnaire




My name is: \_\_\_\_\_



I like to be called: \_\_\_\_\_

My date of birth: \_\_\_\_\_

My telephone number: \_\_\_\_\_



We would like to share information about you with other health professionals. Is this okay?



 or 


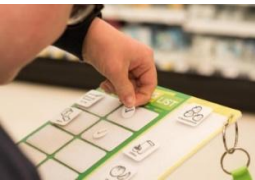
Did anyone help you fill in this form?

 or 

My first language is \_\_\_\_\_

Do you have any difficulty communicating?

 or 

I communicate by: (tick as many as you like)

Talking

Signing

Using a communication aid

Pointing

Using gestures

Other (please specify) \_\_\_\_\_

I can understand information if it is:


Written word

With pictures

Communicated verbally

Interpreted by a carer

Other (please specify) \_\_\_\_\_





My next of kin is: \_\_\_\_\_

My main carer is: \_\_\_\_\_


I live with: \_\_\_\_\_

Do you see anyone from the Learning Disabilities Team?





or


Name: \_\_\_\_\_





Do you have a health action plan?




or


Do you have a hospital passport?





or


If you do, please bring them to your health check appointment




Do you have any allergies?





or


If yes, please list your allergies: \_\_\_\_\_





Do you have any problems taking your medication?




or



Do you take any over-the-counter medication?




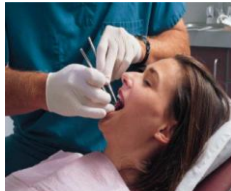
or





Do you have any medical fears or phobias e.g. blood samples taken, blood pressure checks, injections?




or


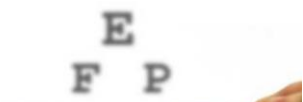


Do you have any problems with your teeth or mouth?












or







When did you last go to a dentist? \_\_\_\_\_










Do you have any problems with your vision?

	<input type="checkbox"/>	or		<input type="checkbox"/>
When did you last go to an optician? _____				










	Do you have any hearing difficulty?				
		<input type="checkbox"/>	or		<input type="checkbox"/>
	Do you wear a hearing aid?				
		<input type="checkbox"/>	or		<input type="checkbox"/>
	Have you had your hearing checked?				
		<input type="checkbox"/>	or		<input type="checkbox"/>

	Do you have any problems with your feet?				
		<input type="checkbox"/>	or		<input type="checkbox"/>
	Do you visit a podiatrist?				
		<input type="checkbox"/>	or		<input type="checkbox"/>


	Do you have any problems with your mobility?
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	<input type="checkbox"/>	or		<input type="checkbox"/>
Do you use any mobility aids e.g. wheelchair, stick or frame?				
	<input type="checkbox"/>	or		<input type="checkbox"/>
Do you see a physiotherapist or an occupational therapist?				
	<input type="checkbox"/>	or		<input type="checkbox"/>



Do you have any problems with eating and drinking?

		<input type="checkbox"/>	or		<input type="checkbox"/>
Do you see a dietician?					
		<input type="checkbox"/>	or		<input type="checkbox"/>
Do you have any problems with swallowing?					
		<input type="checkbox"/>	or		<input type="checkbox"/>
Do you see a speech and language therapist?					
		<input type="checkbox"/>	or		<input type="checkbox"/>
Do you have any heartburn or indigestion?					



  or 




Do you have any problems going for a poo e.g. constipation or diarrhoea or incontinence?



  or 

Do you have any problems going for a wee e.g. pain, blood or incontinence?


  or 



Do you have epilepsy?



  or 

If yes, how many seizures have you had in the last month? \_\_\_\_\_




**For men and women aged 50-74**

Have you been sent a kit to test for bowel cancer?



  or 

When did you last do the test? \_\_\_\_\_

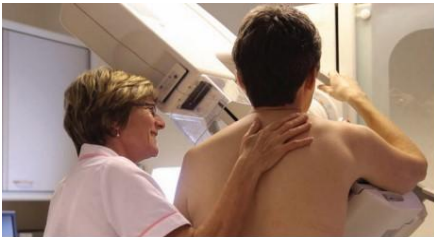
**For men**





Has there been any pain or swelling in your testicles?

  or 

**For women**




Have you noticed any pain or lumps in your breasts?



  or 

If you are over 50 when did you last go for breast screening? \_\_\_\_\_

**For women aged 25- 64**





Have you had a cervical smear test?

  or 

When was your last test? \_\_\_\_\_

**For women**

Do you have periods?

 or 

Any problems with your periods e.g. heavy, painful irregular?




or






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





or




Would you like advice on safe sex and contraception?

 or 




Would you like advice on healthy eating?

 or 





When did you last have a flu vaccine?  
\_\_\_\_\_

Do you drink alcohol?




 or   


How much alcohol do you drink?  
\_\_\_\_\_


Do you take any recreational drugs?

 or 

Do you smoke?

 or 

If yes, how much do you smoke?  
\_\_\_\_\_



How are you feeling?  
\_\_\_\_\_

Is there anything you are worried about?  
\_\_\_\_\_

Anything else you would like to talk to us about?

Thank You for Taking Time to Complete the Form