My Yearly Health Check

eat well

be active

Your Health Matters

stay well

got checked out

Leeds and York Partnership
NHS Foundation Trust

Learning Disability Service
It is important to have a yearly health check.

You can contact your Doctor's surgery and ask for a double appointment with the Practice Nurse for a Yearly Health Check. Fill in this booklet and take it with you to your appointment. This will help the nurse to do a yearly health check with you.

After your health check the information can be used to write a Health Action Plan. There is a blank Health Action Plan at the end of this booklet. The Nurse needs to fill this in to say what health needs she has found.

After seeing the nurse you can add more information about other health needs to the Health Action Plan. You might need help from a health facilitator to do this.

The information for this health check was filled in on

Date ........................................................................................................

Filled in by ..........................................................................................
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Name: ........................................................................................................

Address: ....................................................................................................

..................................................................................................................

Who do you live with? ..................................................................................

Relationship?

Partner ☐ Friend ☐ Family ☐

Do you have a carer?

Yes ☐

No ☐

Paid staff ☐ Friends ☐ Family ☐
Has anyone in your family ever suffered from: (please tick)

<table>
<thead>
<tr>
<th>Disease</th>
<th>Yes</th>
<th>No</th>
<th>Don’t know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stroke</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Diabetes</td>
<td></td>
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<td></td>
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<tr>
<td>Asthma</td>
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<td></td>
</tr>
<tr>
<td>Cancer</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart disease</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Glaucoma</td>
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<td></td>
</tr>
</tbody>
</table>
Does your learning disability have a name?

Do you have any of the following (please tick):

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asthma</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cancer</td>
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<td></td>
</tr>
<tr>
<td>Diabetes</td>
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<td></td>
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<tr>
<td>Renal disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chronic Obstructive Pulmonary disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blood pressure problems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stroke</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thyroid problems</td>
<td></td>
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</tr>
</tbody>
</table>
Medication

Do you take any tablets or medicines?

Yes □

No □

What medicine do you take?

..........................................................................................................................................................
..........................................................................................................................................................
..........................................................................................................................................................
..........................................................................................................................................................

When did you last get your medicine reviewed by the doctor?

6 months □

1 year □

longer □

Does your medicine ever make you feel bad?

Yes □

No □

How does it make you feel? .................................................................................................................
Do you have any problems taking your medication?

Yes ☐
No ☐

What problems do you have taking your medication? ........................................................................

Have you ever had:

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have you had a Hepatitis B injection?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you had a Flu Injection?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you had a Tetanus injection?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Have you had a Hepatitis B injection?
Date:

Have you had a Flu Injection?
Date:

Have you had a Tetanus injection?
Date:

How tall are you? .............................................................................

How much do you weigh? .................................................. Date ........................

Has your weight changed in the last 6 months .............................................................

What is your waist measurement .................................................................
Do you have epilepsy?

Yes ☐  No ☐

What type of seizures?

How often do you have seizures?

Have your seizures changed in the last year?

Yes ☐  No ☐

Do you see a doctor about your epilepsy?

When did you last have an epilepsy review?
Mouth, Ears and Eyes

When did you last go to the Dentist? ..............................................................

Do you have problems with your teeth or mouth? ...........................................

When did you last go to the Optician? ..........................................................

Do you have problems seeing? ...........................................................................

When did you last have your hearing tested?..................................................

Do you have problems hearing?........................................................................

Do you have any problems with your skin?

Yes □ No □

What problems do you have?...........................................................................
Do you have problems sleeping?

- [ ] Yes
- [ ] No

What problems do you have?

Do you sleep during the day?

- [ ] Yes
- [ ] No

Do you have lots of headaches?

- [ ] Yes
- [ ] No

Do you have lots of chest infections?

- [ ] Yes
- [ ] No
Pain

Do you have any pain?

Yes □ No □

Where is the pain?

Is the pain.....

how much pain

no pain □ a little □ painful □ very painful □
Questions for Women

Have you had a cervical screen test (smear test)?

- Yes □
- No □

Have you had breast screening?

- Yes □
- No □

Do you check your own breasts for changes?

- Yes □
- No □

Do you have periods every month?

- Yes □
- No □

Do you have any worries about your periods? .......................................................... ..........................................................................................................................................................................
..........................................................................................................................................................................
..........................................................................................................................................................................

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Do you check your testicles?  

- Yes [ ]  
- No [ ]
## Food eaten

Food and drink I have eaten this week

<table>
<thead>
<tr>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
<th>Saturday</th>
<th>Sunday</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>
Do you ever cough or choke when eating or drinking?

Yes □ No □

Do you ever vomit after eating or drinking?

Yes □ No □

Do you have indigestion or heartburn?

Yes □ No □
Exercise

Exercise I have done this week

<table>
<thead>
<tr>
<th></th>
<th>morning</th>
<th>afternoon</th>
<th>evening</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monday</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tuesday</td>
<td></td>
<td></td>
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<td>Saturday</td>
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<tr>
<td>Sunday</td>
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</tbody>
</table>
Moving about

Do you have problems with your breathing?

Yes □
No □

What problems do you have?..........................................................................................................

Has this got worse in the last year?.........................................................................................

Do you have problems walking and moving about?

Yes □
No □

What problems do you have?..........................................................................................................

Has this got worse in the last year?.........................................................................................

Do you ever have problems moving any part of your body?

Yes □
No □

What problems do you have?..........................................................................................................

Has this got worse in the last year?.........................................................................................
Do you have problems with your feet or toe nails?

Yes □
No □

What problems do you have?

Do you use any equipment to help you?

Yes □
No □

What equipment do you use?
Going to the toilet

Do you have problems going having a poo?

Yes □  No □

What problems do you have?...................................................................................

How often do you poo?...........................................................................................

Has this changed in the last year?............................................................................

Do you use any continence products?

Yes □  No □

Do you have problems going for a wee?

Yes □  No □

What problems do you have?...................................................................................
Choose your poo

Please tick the picture that looks like your poo.

<table>
<thead>
<tr>
<th>Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Separate hard lumps, like nuts (hard to pass).</td>
</tr>
<tr>
<td>2</td>
<td>Sausage-shaped but lumpy.</td>
</tr>
<tr>
<td>3</td>
<td>Like a sausage or with cracks on its surface.</td>
</tr>
<tr>
<td>4</td>
<td>Like a sausage or snake, smooth and soft.</td>
</tr>
<tr>
<td>5</td>
<td>Soft blobs with clear-cut edges (passed easily).</td>
</tr>
<tr>
<td>6</td>
<td>Fluffy pieces with ragged edges, a mushy stool.</td>
</tr>
<tr>
<td>7</td>
<td>Watery, no solid pieces Entirely Liquid.</td>
</tr>
</tbody>
</table>
Have you been given information about safe sex and contraception?

- Yes □
- No □

Would you like information about safe sex and contraception?

- Yes □
- No □
Mental Health

Do you have a mental health problem?

Yes □

No □

Does your mental health problem have a name?

What is the name of your psychiatrist?

Do you have a community nurse?

Yes □

No □

What is the name of your community nurse?
Your Feelings

How have you been feeling in the past month? (please tick all that apply to you)

- happy
- anxious
- unhappy
- sad
- angry
- aggressive

Do you have these feeling a lot?

- yes
- no

Yes □
No □

Do you want to talk to someone about your feeling?

- yes
- no

Yes □
No □
Do you smoke?

- Yes [ ]
- No [ ]

How many cigarettes do you smoke each day?

Do you want to stop smoking?

- Yes [ ]
- No [ ]

Do you drink alcohol?

- Yes [ ]
- No [ ]

How much do you drink? How often do you drink?

Are you worried about how much alcohol you drink?

- Yes [ ]
- No [ ]

Do you take any drugs?

- Yes [ ]
- No [ ]

What drugs do you take?
## Health Action Plan

<table>
<thead>
<tr>
<th>Health Issue</th>
<th>Action Needed</th>
<th>Who will do it?</th>
<th>Review Date</th>
</tr>
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<tbody>
<tr>
<td></td>
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