











Dear .....

	<p>I would like to invite you for a Health Check at the surgery.</p>
	<p>Someone from the surgery will contact you to make an appointment.</p>
	<p>It is fine to bring someone with you.</p>
	<p>Your Health Check will take about 1 hour.</p>
	<p>You will see a nurse. Then you will see the doctor.</p>
	<p>You may need to have some tests, like blood tests or a wee/pee test.</p>
	<p>I will check that your body is healthy. I will ask you questions about your health. I will listen to your lungs and heart, and feel your tummy.</p>
	<p>Before your Health Check please answer the questions on the form we have sent you with this letter. It is fine for someone to help you.</p>
	<p>You might also like to think about things that are worrying you. Write them down and we can talk about them when you come in.</p>
	<p>If you do not or are unable to attend your health check, the doctor may tell the Learning Disability Nurse who can support you to come to the GP surgery.</p>

From Doctor .....



## Questions to answer before your Health Check



Please put 1 tick in a box or write the answer for each question.  
It is fine for some to help you.



My name .....



1. We would like to share information about you with other health care professionals. They could be people like
- Dentists who check your teeth
  - Opticians who check your eyes
  - Hospital doctors

Is this OK?

Yes

No













2. Are you getting help to fill in this form?



If yes, who is helping you to fill in this form?

Name .....

3. Do you know your diagnosis? This is the health problem your doctor says you have.					
		Yes		No	Don't know
		<input type="checkbox"/>		<input type="checkbox"/>	 <input type="checkbox"/>
If yes, please tell us about it: ..... ..... .....					
4. Do you have any other health problems? This could be epilepsy, diabetes or something else.					
		Yes		No	Don't know
		<input type="checkbox"/>		<input type="checkbox"/>	 <input type="checkbox"/>
If yes, please tell us about it: ..... ..... .....					
5. Have you ever had an operation?					
		Yes		No	Don't know
		<input type="checkbox"/>		<input type="checkbox"/>	 <input type="checkbox"/>
If yes, please tell us about it: ..... ..... .....					



6. Is there any history of illness in your family?

Yes

No

Don't know



If yes, please tell us about it:

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



7. Do you go to a dentist to have your teeth checked?

Yes

No

Don't know



If yes, when was the last time you went to a dentist?

.....



8. Do you go to an optician to have your eyesight checked?

Yes





No

Don't know







If yes, when was the last time you went to an optician?





.....

	9. Do you go a chiropodist or podiatrist to have your feet checked?				
		Yes		No	Don't know
		<input type="checkbox"/>		<input type="checkbox"/>	

When was the last time you went to a chiropodist or podiatrist?  
 .....

	10. Have you had your hearing checked?				
		Yes		No	Don't know
		<input type="checkbox"/>		<input type="checkbox"/>	

When was the last time you had your hearing checked?  
 .....

	11. Do you have epilepsy? This is an illness which means you may have fits and fall down				
		Yes		No	Don't know
		<input type="checkbox"/>		<input type="checkbox"/>	

If yes, how many fits do you have each month?  
 .....  
 If yes, who is your Epilepsy Doctor or Nurse?  
 .....



12. Do you have any problems going to the toilet?

Yes

No



If yes:

Do you have problems having a wee or pee?  
This is also called passing urine.

Yes

No



Do you have problems having a poo?  
This is also called passing a stool.

Yes

No



13. Is there anything else you want to tell us?  
This could be about aches or pain you get a lot of  
the time.

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.....

.....



# Your Feelings

1. How are you feeling?





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



2. Do you have any worries?



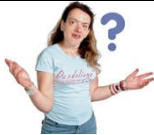


	Yes		No
	<input type="checkbox"/>		<input type="checkbox"/>

If yes:



Have you spoken to anyone to get help with these worries?

	Yes		No	Don't know	
	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>



# The food you eat



1. Do you have problems eating your food?  
This could be with chewing or swallowing.



Yes

No



If yes, please tell us about the problems:

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



2. Are there any foods you cannot eat?  
Are there any foods you need to eat?  
This could be because you have a particular medical  
problem. Some people will be ill if they eat the  
wrong things.

Yes

No

Don't know



















If yes, please tell us about this:

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







	<h2>How I live my life</h2>			
<p>1. Do you smoke?</p>				
		Yes		No
		<input type="checkbox"/>		<input type="checkbox"/>
<p>2. Do you drink alcohol?</p>				
		Yes		No
		<input type="checkbox"/>		<input type="checkbox"/>
<p>3. Do you want information about how to stop smoking or drinking?</p>				
		Yes		No
		<input type="checkbox"/>		<input type="checkbox"/>
<p>4. Do you exercise?</p>				
		Yes		No
		<input type="checkbox"/>		<input type="checkbox"/>
<p>5. Do you get the chance to exercise?</p>				
		Yes		No
		<input type="checkbox"/>		<input type="checkbox"/>



6. Do you have any hobbies

		Yes		No
		<input type="checkbox"/>		<input type="checkbox"/>



If yes, what are your hobbies?

.....



.....

.....

.....





7. Do you have a job?

		Yes		No
		<input type="checkbox"/>		<input type="checkbox"/>





If no, do you want a job?

		Yes		No
		<input type="checkbox"/>		<input type="checkbox"/>





8. Are you a volunteer?

This means working but not getting money for it.

		Yes		No
		<input type="checkbox"/>		<input type="checkbox"/>



9. Do you live in a house or flat on your own?

		Yes		No
	<input type="checkbox"/>		<input type="checkbox"/>	

If no, who else do you live with?

.....




.....

.....

.....



10. Are you getting support to do the things you want to do?

	Yes		No	Don't know	
	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>

# You need to bring these things with you to your Health Check:



1. A jar with your wee or pee in it.  
This is called a urine sample.



2. Your tablets or medicines, if you have any.  
Please list the names of your tablets and medicines here:

.....

.....

.....

.....

.....

.....

.....



3. Your Health Action Plan if you have one.








4. Your Hospital or Patient Passport if you have one.



# Medicines Reminder Chart

- You can fill in this chart with the names of the tablets or medicines you need to take each day.
- You can write down when you should take them and how much you need.
- This will help you to remember to take your tablets and medicines.

				
Medicines or tablets	Breakfast	Midday	Evening meal	Bedtime