**Community Integrated Learning Disability Service, Adults and Health Directorate, Nursing team**

London Borough of Barnet, 2 Bristol Avenue, Colindale, NW9 4EW. Tel: 0208 359 6161 clcht.gpldnurse@nhs.net

|  |
| --- |
| **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? | | | |
|  | or |  |  |
| When did you last go to an optician? | | | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Do you have any hearing difficulty? | | | |
|  | or |  |  |
| Do you wear a hearing aid? | | | |
|  | or |  |  |
| Have you had your hearing checked? | | | |
|  | or |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Do you have any problems with your feet? | | | |
|  | or |  |  |
| Do you visit a podiatrist? | | | |
|  | or |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Do you have any problems with your mobility? | | | |
|  | or |  |  |
| Do you use any mobility aids e.g. wheelchair, stick or frame? | | | |
|  | or |  |  |
| Do you see a physiotherapist or an occupational therapist? | | | |
|  | or |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Do you have any problems with eating and drinking? | | | |
|  | or |  |  |
| Do you see a dietician? | | | |
|  | or |  |  |
| Do you have any problems with swallowing? | | | |
|  | or |  |  |
|  | Do you see a speech and language therapist? | | | |
|  |  | or |  |  |
|  | 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 60-69**  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

**Community Integrated Learning Disability Service, Adults and Health Directorate, Nursing team**

London Borough of Barnet, 2 Bristol Avenue, Colindale, NW9 4EW. Tel: 0208 359 6161 [clcht.gpldnurse@nhs.net](mailto:clcht.gpldnurse@nhs.net)