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| **Getting ready for your Annual Health Check**  Annual Health Checks are:  To help you stay well and healthy | |
| **About having an Annual Health Check – click link for**[**Easy Read Guide**](https://www.mencap.org.uk/sites/default/files/2016-06/Annual_health_checks_Easy_Read_1.pdf) | |
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| C:\Users\jane\Downloads\iPhone (3).pngEmailC:\Users\jane\Downloads\Letter Health Check.png | **Please remind me of appointments by:**   * Text * Phone * Email * Letter/post |
| **Summary care records**  If you would like **extra information** on your summary care record about **your health** and what **support,** you need let your Doctor know.  **Please answer Yes or No to say if you need more information.** | |
| **For Easy Read resources about Summary Care Records click** [**here**](https://www.mencap.org.uk/sites/default/files/2019-05/SCR_AI_Easy_Read_Patient_Leaflet.pdf) | |
| **Yes/No** | **I would like** extra information on mySummary Care Record. |

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| **Consent to sharing information**  Consent is being asked if you agree to something.  This means saying yes or no to the questions below.  **Please answer Yes or No to say if you agree.** | | |
| **For easy read resources about consent click** [**here**](https://www.ouh.nhs.uk/patient-guide/leaflets/documents/consent.pdf) | | |
| **Yes/No** | | 1. Consent for electronic record sharing? |
| **Yes/No** | | 1. Consent to share data with another Professional? (Someone who works to help you) |
|  | | |
| **Yes/No** | | I am not able to consent to sharing my information. |
| **Yes/No** | | It has been agreed that it is in my Best Interest to share information. |
| **Reasonable Adjustments**  A reasonable adjustment is a change your Doctor needs to make so going to the surgery is easier for you. **Please answer Yes or No for ways we can help you.** | |

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| Easy Read Info 1 (1) | I need **Easy Read**documents. | **Yes/No** |
| I need information in **Braille.** | **Yes/No** |
| I need information in**Large print.** | **Yes/No** |
| I need an **interpreter**. | **Yes/No** |
|  | | |
| Hoist | I use a **wheelchair** and Iwill need a **hoist** if I needa physical examination. | **Yes/No** |
| I may need a **home visit**. | **Yes/No** |
|  | | |
| Waiting Room 1 | I would like to come at **quiet times**, because I find it difficult waitingfor my appointment. | **Yes/No** |
| I may need to **wait outside** until you are ready to see me. | **Yes/No** |
| **Bright lights** or **loudnoises** may affect me. I may need to sit in a quiet room. | **Yes/No** |
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| Timer 15Timer 30 | I need **longer Appointments** | | **Yes/No** |
|  | I need **support** with medical procedures.  Like having an i**njection**, **blood test** or **blood pressure** test. | | **Yes/No** |
| Please say how you have tolerated these tests in the past (what has helped make them easier for you). | | |
|  | | | |
|  | My **carer** will support youto understand my needs. | | **Yes/No** |
| I get very **nervous** atappointments and needmy carer to support me. | | **Yes/No** |
| Please tell my carerabout any appointments. | | **Yes/No** |
|  | | | |
| NHS Flag (1) | These are the other **things** that will help me… | | |
| Timetable 2 | **Your measurements**  This is really important and helpful information | | |
| GP Height | **Height** |  | |
| Scales | **Weight** | (Are you putting on weight or losing weight?) | |
| Blood Pressure Happy | **Blood Pressure** |  | |
| Fingertip Pulse Oximeter | **Other** |  | |
|  | | | |
| Please**chooseYes** or **No**to **tell** the doctor about any **problems** and what is **important** for you | | | |
| Flu Vaccine Tray | **Flu** | **Answer** | **Your notes...**  **Writing** |
| Have you had your **nasal spray** or a **flu** vaccine **injection**? | **Yes/No** |  |
| Walking frame  Elderly Fall 3 | **Mobility**  **moving** | **Answer** | **Your notes...**  **Writing** |
| Stiffness or difficulty moving? | **Yes/No** |  |
| Pain when moving? | **Yes/No** |  |
| Falling or tripping? | **Yes/No** |  |
| Changes in posture or mobility? | **Yes/No** |  |
| Swelling or redness in limbs or skin | **Yes/No** |  |
| Mobility equipment used | **Yes/No** |  |

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| **Unhealthy 1** | | **Being Healthy** | **Answer** | **Your notes...**  **Writing** |
| Healthy 1 (1) | | **Diet**  Do you eat fruit and vegetables? | **Yes/No** |  |
| Winner1 | | **Exercise**  Do you exercise? | **Yes/No** | What exercise do you do? |
| Cigarettes Pack | | **Smoking**  Do you smoke/vape? | **Yes/No** | How much do you smoke/vape in a day? |
| LagerWine | | **Alcohol**  Do you drink alcohol? | **Yes/No** | How much alcohol do you drink in a week? |
| Cannabis JointDrugs white powder (1) | | **Drugs**  Do you use illegal drugs? | **Yes/No** | If Yes, which ones? |
|  | | | | |
| Condom | | **Sexual Health & Contraception** | **Answer** | **Your notes...**  **Writing** |
| Do you have sex? | **Yes/No** |  |
| Do you use contraception? | **Yes/No** |  |
| [**Guides**](https://www.choicesupport.org.uk/about-us/what-we-do/supported-loving/supported-loving-toolkit) **to support people with learning disabilities with issues around sex and relationships** | | | | |
|  | | | | |
| Bowel cancer screening in England | Bowel Cancer UK | | **Bowel Cancer check** | **Answer** | **Your notes...**  **Writing** |
| Are you aged  60-74? | **Yes/No** | Age: |
| If yes, have you received your bowel test kit? | **Yes/No** |  |
| **Bowel Screening an Easy Guide: Click** [**here**](https://www.gov.uk/government/publications/bowel-cancer-screening-easy-guide) | | | | |
| Gender Female | **Female health checks** | | **Answer** | **Your notes...**  **Writing** |
| Body breasts f (1) | Do you check your breasts? | | **Yes/No** |  |
| Have you seen or feltchanges to your breasts? | | **Yes/No** |  |
| Have you had breast screening? (age 50+) | | **Yes/No** |  |
| When Do I Need to Get a Pap Smear? | Have you had a smear test? | | **Yes/No** |  |
| Hot flush (1)Sanitary towel | Change in periods? e.g. heavy bleeding in between periods | | **Yes/No** |  |
| Painful periods | | **Yes/No** |  |
| [Vaginal discharge](https://www.nhs.uk/conditions/vaginal-discharge/) | | **Yes/No** |  |
| Menopause symptoms | | **Yes/No** |  |
| **USEFUL LINKS AND INFORMATION**  [**Puberty and period in girls with developmental delay**](https://www.myfamilyourneeds.co.uk/support-child/puberty-and-periods-in-girls-with-developmental-delay/)  [**An easy guide to cervical screening**](https://www.gov.uk/government/publications/cervical-screening-easy-read-guide)  [**An easy guide to breast screening**](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/765594/Easy_guide_to_breast_screening.pdf)  [**Supporting people with learning disabilities to take care of their breasts**](http://www.resourcesorg.co.uk/assets/pdfs/taking%20care%20of%20your%20breasts%20-Guide%20for%20supporter2.pdf)  [**How to check your breasts**](https://breastcancernow.org/sites/default/files/publications/pdf/bcc211_know-your-breasts_miniguide_2021_web.pdf) | | | | |
| Gender Male | **Male health checks** | | **Answer** | **Your notes...**  **Writing** |
| Body testicles m | Do you check your  testicles / balls? | | **Yes/No** |  |
| Have you seen or felt changes to your  testicles / balls? | | **Yes/No** |  |
| Heart 2 | Have you had your  [Abdominal Aortic](https://www.nhs.uk/conditions/abdominal-aortic-aneurysm-screening/)  [Aneurysm](https://www.nhs.uk/conditions/abdominal-aortic-aneurysm-screening/) or AAA  check? **(Age 65 +)?** | | **Yes/No** |  |
| **USEFUL LINKS AND INFORMATION**  [**Puberty in boys with developmental delay**](https://www.myfamilyourneeds.co.uk/support-child/puberty-in-boys-with-additional-needs/)  [**How to look after my balls**](https://www.macmillan.org.uk/documents/cancerinfo/easyreadpdfs/testicularcancerandself-checking%5bpdf,434mb%5d.pdf)  [**Abdominal Aortic Aneurysm or AAA screening**](https://www.nhs.uk/conditions/abdominal-aortic-aneurysm-screening/) | | | | |
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| Body eye f | **Eyes** | | **Answer** | **Your notes...**  **Writing** |
| Have you had your eyes tested? | | **Yes/No** | What date was your eye test: |
| Do you have any eyesight problems or wear glasses? | | **Yes/No** |  |
|  | | | | |
| Body ear m | **Ears** | | **Answer** | **Your notes...**  **Writing** |
| Have you noticed any problems orchanges to your hearing? | | **Yes/No** |  |
| Have you had an ear test? | | **Yes/No** | Date: |
|  | | | | |
| Teeth | **Teeth** | | **Answer** | **Your notes...**  **Writing** |
| Do you have a dentist? | | **Yes/No** |  |
| When was your last visit? | |  | Date: |
| Do your teeth hurt? | | **Yes/No** |  |
| Do your gums bleed? | | **Yes/No** |  |
| Do you have a swelling or a lump? | | **Yes/No** |  |
| Do you have difficulty eating? | | **Yes/No** |  |
| Breathe deep (3) | **Respiratory**  Chest & Breathing | | **Answer** | **Your notes...**  **Writing** |
| Is it hard to breathe? | | **Yes/No** |  |
| Coughing that won’t go away | | **Yes/No** |  |
| Chest infections | | **Yes/No** |  |
| Coughing up blood | | **Yes/No** |  |
| Unusual coloured spit | | **Yes/No** |  |
| Wheezing | | **Yes/No** |  |
| Hay fever, allergies, asthma? | | **Yes/No** |  |
|  | | | | |
| IBS (1) | **Bowels and Poo** | | **Answer** | **Your notes...**  **Writing** |
| Constipation - hard poo or can’t poo | | **Yes/No** |  |
| Watery poo and going too much | | **Yes/No** |  |
| Bleeding from your bottom | | **Yes/No** |  |
| Difficulty getting to the toilet on time | | **Yes/No** |  |
| Changes in having a poo | | **Yes/No** |  |
| Indigestion | | **Yes/No** |  |
| [**Information and easy read guides about constipation**](https://www.england.nhs.uk/publication/constipation-learning-disability-resources/) | | | | |
| Need a wee (1) | **Urine / wee** | | **Answer** | **Your notes...**  **Writing** |
| Does it hurt when you wee? | | **Yes/No** |  |
| Have you had a urine infection? | | **Yes/No** |  |
| Do you wee more often? | | **Yes/No** |  |
| Do you find it difficult to start weeing? | | **Yes/No** |  |
| Do you start and stop when weeing? | | **Yes/No** |  |
| Is there ever blood in your wee? | | **Yes/No** |  |
| Difficulty getting to the toilet on time? | | **Yes/No** |  |
|  | | | | |
|  | | | | |
| Heart 2 | **Heart** | | **Answer** | **Your notes...**  **Writing** |
| Is it difficult to breath? | | **Yes/No** |  |
| Do you have chest pain when exercising? | | **Yes/No** |  |
| Any swelling to the ankles, hands or body? | | **Yes/No** |  |
|  | | | | |
| Brain Seizure | **Epilepsy**  **Brain** | | **Answer** | **Your notes...**  **Writing** |
| **If you have epilepsy please answer these questions.**  **Please bring your seizure chart with you, if you have one.** | | | |
| How many seizures per month? | |  |  |
| Any changes to seizures? | | **Yes/No** |  |
| Are you under the care of a specialist (neurologist)? | | **Yes/No** | When did you last see them? |
| Do you take your epilepsy medication when you should? | | **Yes/No** |  |
| Do you have any side effects i.e. feeling dizzy, sick, irritable or have blurred version? | | **Yes/No** |  |
|  | | | | |
|  | | | | |
| Diabetes test2 | **Diabetes** | | **Answer** | **Your notes...**  **Writing** |
| **If you have diabetes please answer these questions**  Please bring your blood sugar charts if you have them | | | |
| Do you test your blood sugar regularly? | | **Yes/No** |  |
| Do you have any problems with your eye sight? | | **Yes/No** |  |
| Have you been for your diabetic eye test? | | **Yes/No** |  |
| Body feet f | **Feet** | | **Answer** | **Your notes...**  **Writing** |
| Have you been to a  podiatrist or foot specialist? | | **Yes/No** | If yeswhen did you go? |
| If no, who cuts your nails? | | **Yes/No** |  |
| Do you have any pain in your feet? | | **Yes/No** |  |
|  | | | | |
| Headache | **Pain** | | **Answer** | **Your notes...**  **Writing** |
| Do you have any pain? | | **Yes/No** |  |
| Does your pain medicine help? | | **Yes/No** |  |
|  | | | | |
|  | **Skin** | | **Answer** | **Your notes...**  **Writing** |
| Do you have Dry or Itchy Skin? | | **Yes/No** |  |
| Changes to moles? | | **Yes/No** |  |
| Cold Sores? | | **Yes/No** |  |
| Sores or open wounds? | | **Yes/No** |  |
| Changes to the colour of your skin? | | **Yes/No** |  |
| Stress | **Mental Health** | | **Answer** | **Your notes...**  **Writing** |
| Feeling low, sad or unhappy? | | **Yes/No** |  |
| Feeling worried, frightened or anxious? | | **Yes/No** |  |
| Do you feel like crying? | | **Yes/No** |  |
| Do you feel like you can’t cope? | | **Yes/No** |  |
| Do you feel irritable, aggressive or violent? | | **Yes/No** |  |
| Think about hurting yourself or actually hurt yourself? | | **Yes/No** |  |
| Sleeping too much or not sleeping? | | **Yes/No** |  |
| Do you hear voices or see things? | | **Yes/No** |  |
| Worries about your memory orconfusion? | | **Yes/No** |  |
| Have you spoken to someone about  how you feel? | | **Yes/No** |  |
| **Mental Health and Learning Disabilities information**  [**Easy Read leaflets and guides**](https://www.rcpsych.ac.uk/mental-health/problems-disorders/learning-disabilities) | | | | |
|  | **Medication Review**  Your Doctor will talk to you about your medicines to make sure your medicines are right for you. | | | |
| Do you have any **concerns** or **questions** about your medication? | | | **Yes/No** |  |
| [**Guide for supporting a person to a GP appointment to talk about psychotropic medication**](https://www.vodg.org.uk/wp-content/uploads/2017-VODG-Preparing-to-visit-a-doctor-to-talk-about-psychotropic-medication.pdf) | | | | |

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| 394AA36 | **End of Life Care** | | | |
| Do you have a ‘**DNAR’** (Do Not Attempt  Resuscitation) or **‘ReSPECT’**(Recommended Summary Plan for Emergency Care and Treatment)Form? | | **Yes/No** |  | |
| Do you have any **concerns**or **questions** about these documents? | | **Yes/No** |  | |
| [**RESPECT information for patients and carers**](https://www.resus.org.uk/respect/patients-and-carers/) | | | | |
|  | | | | |
|  | **My Care Passport**  Help hospital staff understand howto help you. Click [**here**](https://www.uhsussex.nhs.uk/content/uploads/2022/11/My-care-passport-1.pdf) for your My Care Passport. | | |  |
| Do you have a My Care Passport? | | **Yes/No** |  | |
| Question 4 | **Do you have any Questions?**  Is there anything you want the Doctor or Nurse to know? | | | |
|  | | | | |
| Health Action Plan (2) | **Health Action Plan**  At the end of your Annual Health Check **you** should **get** a copy of your **Health Action Plan**. | | | |
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| Assessment | **Thank you** for filling out this form  Please **email** it back to your GP surgery or**bring it** to the **Annual Health Check Meeting**. | | | |

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| Health Action Plan (2) | **My Health Action Plan**  Notes |

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| **What I will do?** | **When I will do it** | | **Who will help me?** | | |  | | --- | | **I have done it!** | |
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