Ponteland Medical Group

Learning Disability Annual Health Check
Pre-Appointment Questionnaire

Please complete this questionnaire before your Annual Health Check appointment and return it to the surgery.

Have your contact details changed?
Please write on any changes.

<insert contact label here>

How do you prefer to be contacted?

- ☐ In writing
- ☐ By phone
- ☐ By email

Do you have a care manager?

……

Do you have anybody that supports you?

……

The Equality Act 2010 – Reasonable Adjustments

Reasonable adjustments are small changes that can be made to your health appointments that will help support you. Some examples of reasonable adjustments might be:

- Easy read information
- Longer appointments
- Quiet waiting rooms
- A family member or carer to support you at appointments
- A hoist for a physical examination or home visit

What can we do to help you at appointments? Please let us know here

……

……

……

……

Mouth

		Comments
Do you have a dentist? When was the last time you went?	☐ Yes ☐ No	
Do you have any pain in your mouth or teeth?	☐ Yes ☐ No	Comments
Do your gums bleed?	☐ Yes ☐ No	Comments
Do you have any difficulty eating or drinking?	☐ Yes ☐ No	Comments

Eating and drinking

Have there been any changes to your appetite?

Yes ☐ No ☐

Comments

Do you ever feel sick?

Yes ☐ No ☐

Comments

Do you have difficulty swallowing?

Yes ☐ No ☐

Comments

Do you cough when you eat or drink?

Yes ☐ No ☐

Comments

Have you had help from a speech and language therapist with your eating? If so when?

Yes ☐ No ☐

Comments

Weight

Comments

Have you lost or put on any weight in the last 6 months?

Yes ☐ No ☐

If you know, please tell us your recent weight ☐

Bowels / Poo

Do you get any constipation? This is where you can't go to the toilet or your poo is very hard

Yes ☐ No ☐

Comments

Do you get any diarrhoea? This is where you poo is watery

Yes ☐ No ☐

Comments

Have you had any bleeding from your bottom?

Yes ☐ No ☐

Comments

Have there been any changes with how often or little you go to the toilet for a poo?

Yes ☐ No ☐

Comments

If you are between the ages of 60 – 74 have you received your bowel screening kit?

Yes ☐ No ☐

Comments

Urine / Wee

Have you had any pain when you wee?

Yes ☐ No ☐

Comments

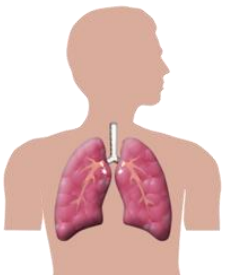
Are you weeing more often?

Yes ☐ No ☐

Comments

Chest and Lung Health

Breathing



Have you had a cough that won't go away?

☐ Yes ☐ No

Comments

Have you had a chest infection recently?

☐ Yes ☐ No

Comments

Have you coughed up any blood or anything unusual?

☐ Yes ☐ No

Comments

Have you had any wheeziness? You make a squeaking noise when you breathe in.

☐ Yes ☐ No

Comments

Have you any breathlessness? Feeling like you can't get enough air when you breathe

☐ Yes ☐ No

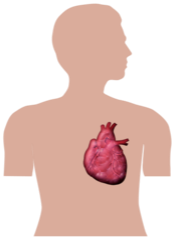
Comments

Do you smoke?

☐ Yes ☐ No

Comments

Heart

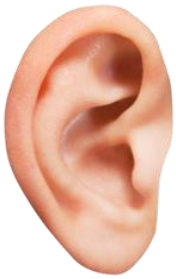


Do you get any chest pain when exercising?

☐ Yes ☐ No

Comments

Hearing



Have you noticed any changes or problems with your hearing?

Yes ☐ No ☐

Comments

Have you been to get your hearing checked?

Yes ☐ No ☐

Comments

Eyes

Comments

Have there been any problems with your eyes?

Yes ☐ No ☐

When did you last have your eyes tested by an optician?

Comments

Do you wear contact lenses or glasses?

Yes ☐ No ☐

Comments

Feet

Do you have any pain in your feet?

Yes ☐ No ☐

Comments

Do you cut your own toe nails?

Yes ☐ No ☐

Comments

Do you see a podiatrist? When did you last see them?

Yes ☐ No ☐

Comments

Mobility

Do you have any pain or difficulty moving?

☐ Yes ☐ No

Comments

Do you use a walking aid eg stick or wheelchair?

☐ Yes ☐ No

Comments

Have you had any falls or trips?

☐ Yes ☐ No

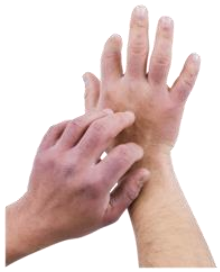
Comments

Do you do any regular exercise?

☐ Yes ☐ No

Comments

Skin



Do you have dry or itchy skin?

☐ Yes ☐ No

Comments

Do you have any warts or cold sores?

☐ Yes ☐ No

Comments

Are you prescribed any skin cream?

☐ Yes ☐ No

Comments

Have you noticed any changes to your skin, freckles or moles?

☐ Yes ☐ No

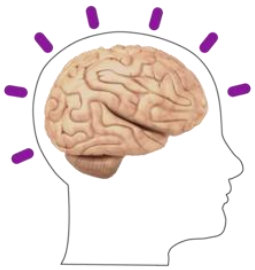
Comments

Do you have any sores or open wounds?

☐ Yes ☐ No

Comments

Brain Part 1



Do you have epilepsy?

Yes ☐ No ☐

Comments

If you have epilepsy:

Have there been any changes to your seizures?

Yes ☐ No ☐

Comments

Do you see an epilepsy specialist? If so when did you last see them?

Yes ☐ No ☐

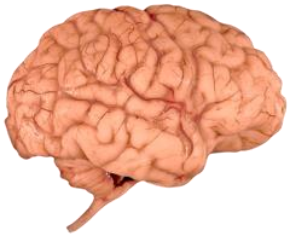
Comments

Do you take epilepsy medication regularly and as prescribed?

Yes ☐ No ☐

Comments

Brain Part 2



Have you become more forgetful than usual?

Yes ☐ No ☐

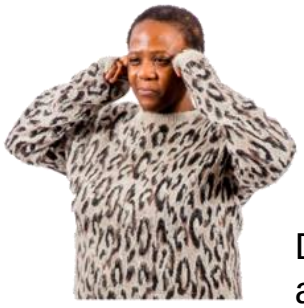
Comments

Have you had any confusion?

Yes ☐ No ☐

Comments

Mental Health



	Yes	No	Comments
Are you feeling sad or unhappy?	☐	☐	
Are you crying, worried, frightened or anxious?	☐	☐	
Have you hurt yourself since your last annual health check?	☐	☐	
Have you ever thought about hurting yourself or anyone else?	☐	☐	
Do you hear voices or see things?	☐	☐	
Do you ever feel aggressive or violent?	☐	☐	
Do you feel like you can't cope or look after yourself?	☐	☐	
Do you talk to anybody about how you feel?	☐	☐	
Do you drink any alcohol? How much?	☐	☐	
Do you take any illegal drugs? Please be honest we are here to help you	☐	☐	

Pain

Do you have any pain anywhere?

☐ Yes ☐ No

Comments

Do you take any medicine which helps stop or relieve the pain?

☐ Yes ☐ No

Comments

Medication Review

What medication do you currently take?

……

……

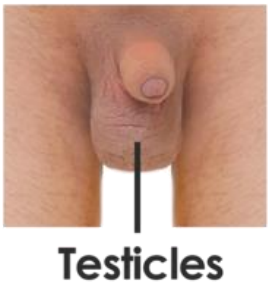
……

Have you had any side effects or problems with your medications?

☐ Yes ☐ No

Comments

Health Screening – Men only



Do you check your own testicles / balls for any changes?

☐ Yes ☐ No

Comments

Have you noticed any lumps or changes?

☐ Yes ☐ No

Comments

Sexual Health

Are you sexually active?

☐ Yes ☐ No

Comments

Questions and notes

Is there anything else you want us to know or questions you want to ask?