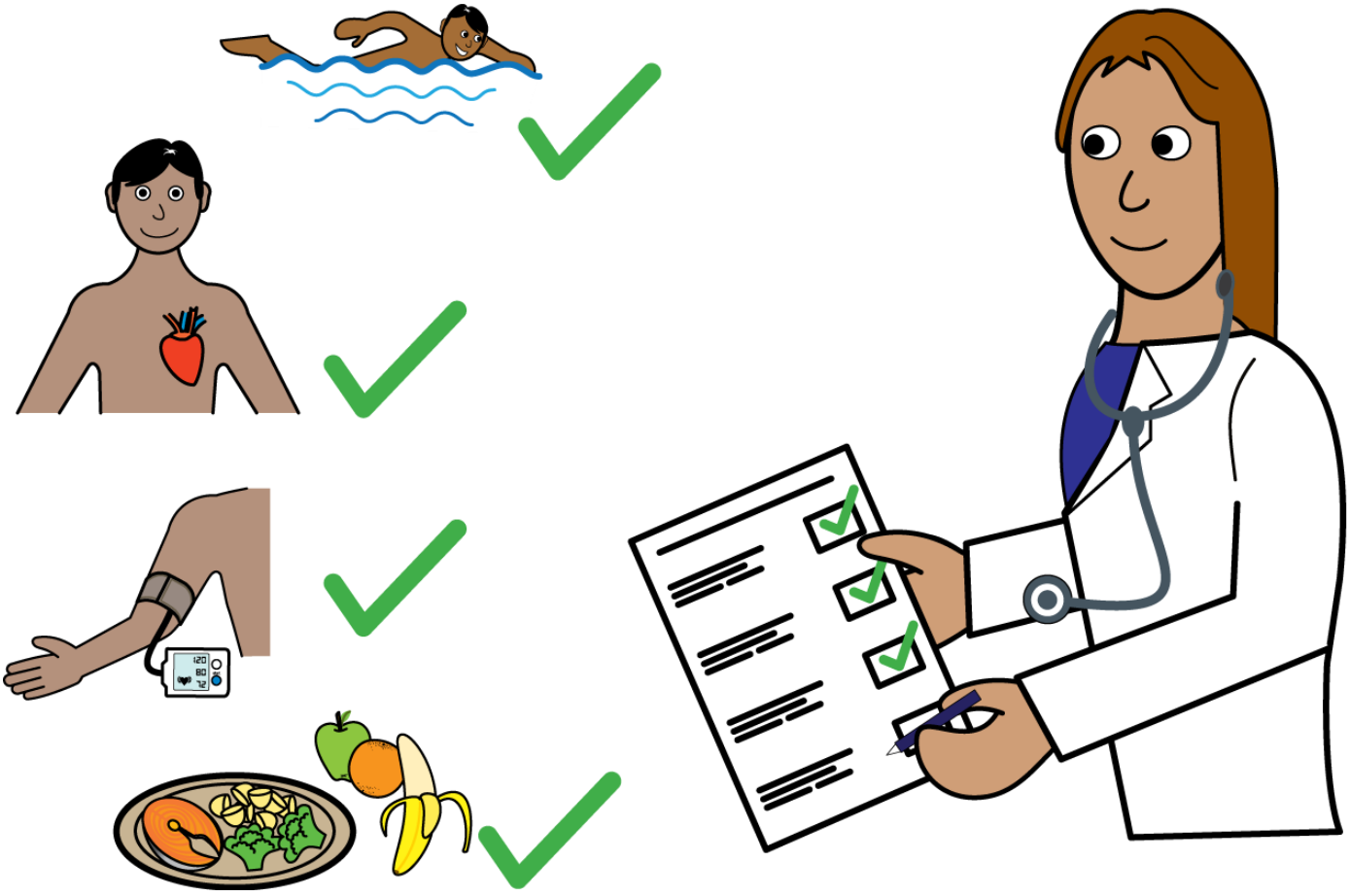
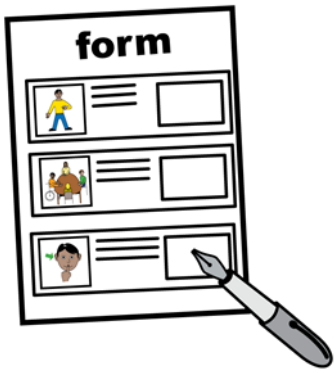
NHS
Berkshire West
Clinical Commissioning Group

Health Check Questionnaire

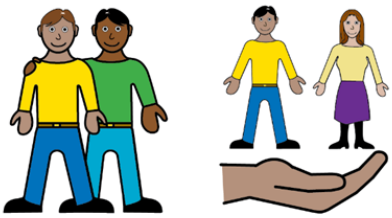


This document has been created in Easy Read by CLASP

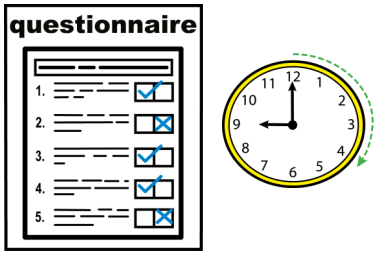
About this questionnaire



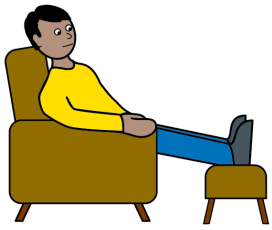
Fill in this questionnaire before your Health Check



You can ask your friend or your carer to help you

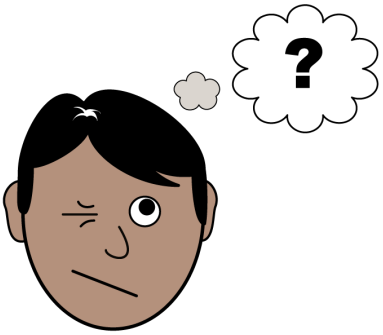


The Questionnaire is very long and it might take you a long time to fill it in



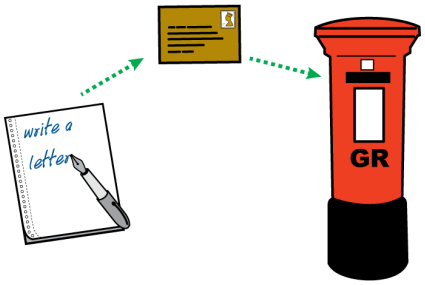
You can take a break and come back to it later if you need to

About this questionnaire



If there is a question you don't want to answer or don't know how to answer

leave it and go to the next question

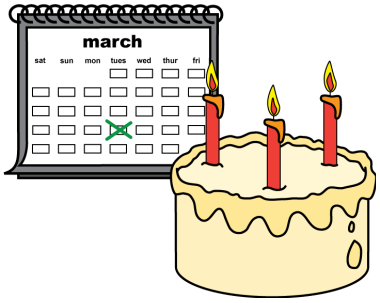


When you have finished filling in the questionnaire send it back to your doctor

Your doctor will contact you to book a date for your health check

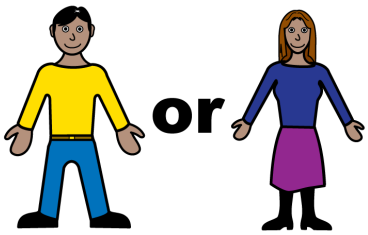
About you

Name



Date of birth

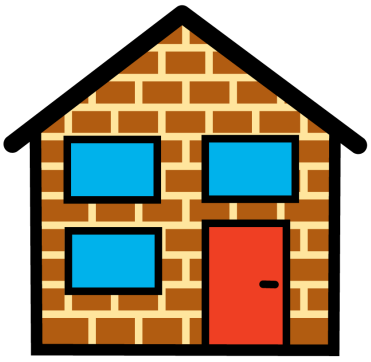
Day Month Year



Male Female Other

Address

Where you live



Where do you live
What sort of place is it

☐ Your family home

☐ Residential care home

☐ Your own flat or house

☐ Supported living home

Your care and support

Who supports you

If you don't have any support leave the boxes blank

Family carer

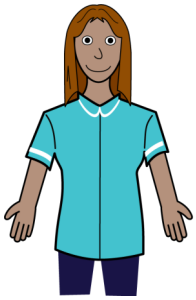
Name of family carer

Family carer phone number

Family carer email address

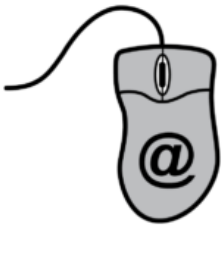
The language your family carer speaks and understand best

Paid support worker / carer



Name of support worker / carer

Support workers phone number



Support workers email address

Social worker if you have one

Name of social worker

Social workers phone number

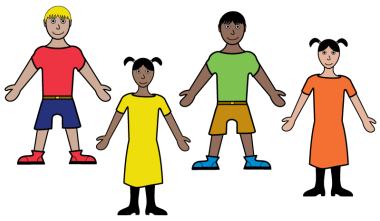
Social workers email address

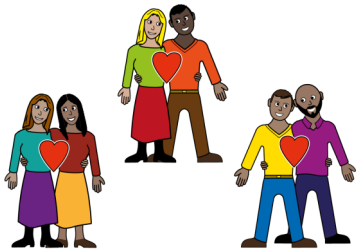
Care and support you give

Are you a carer for anyone
This could be children, parents or your partner

Yes ☐ No ☐

If you ticked **yes** who do you care for?

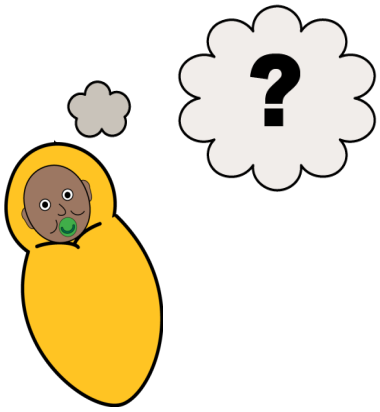




Your learning disability

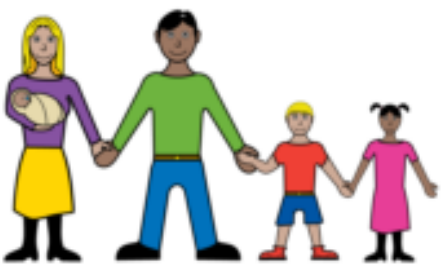
Does your type of learning disability have a name

If you do not know leave the box blank



Were you born with the learning disability or did something cause it

If you do not know leave the box blank



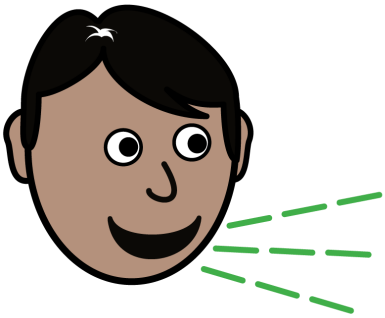
Do other people in your family have a learning disability

Yes ☐ No ☐

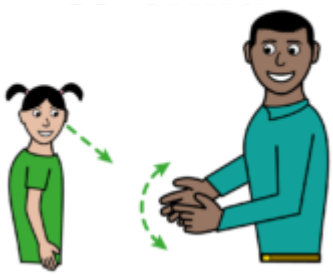
Communication

How do you communicate

tick as many as you like

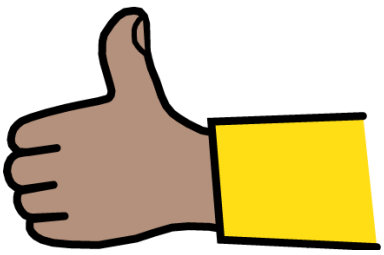


☐ Talking



☐ Signing

☐ Using a communication aid



☐ Pointing and gestures

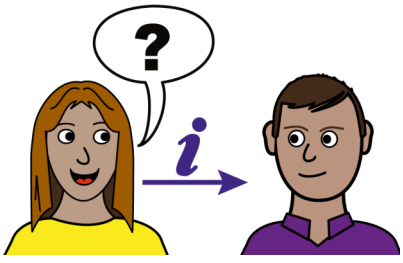
Communication

Which language do you speak and understand best

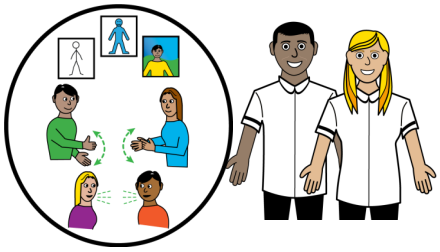
Do you find it difficult to communicate

Yes ☐ No ☐

If you ticked yes what helps you to communicate



Communication



Do you see a speech therapist to help you with communication

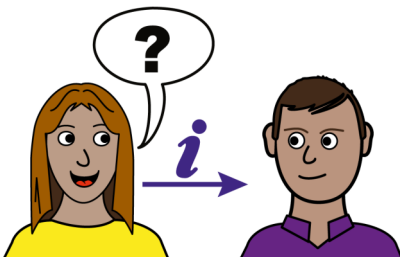
Yes ☐ No ☐

Medical fears / phobias

Do you have any medical fears / phobias

A phobia is a very strong fear of a thing or place

Yes ☐ No ☐

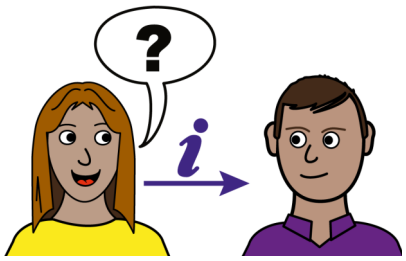


If you ticked **yes** what

Employment

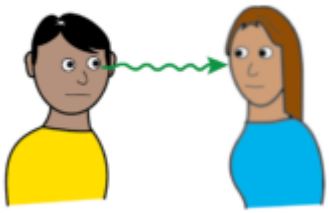
Do you have a job

Yes ☐ No ☐



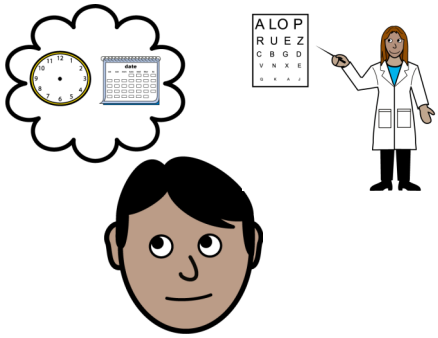
If you ticked **yes** what is your job

Your eyesight



Do you have any problems with your eyes or find it hard to see things

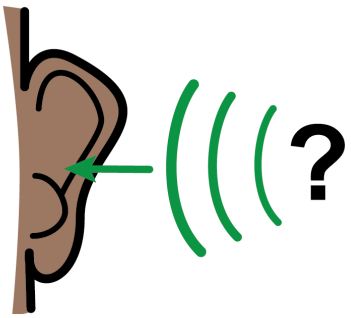
Yes ☐ No ☐



What was the date of your last optician's appointment

Day Month Year

Your hearing

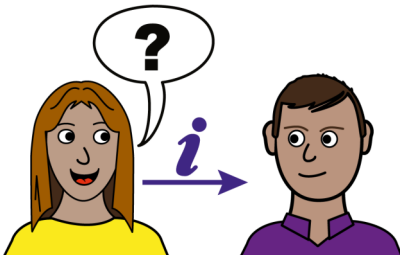


Do you have any difficulty hearing or find it hard to hear

Yes ☐ No ☐

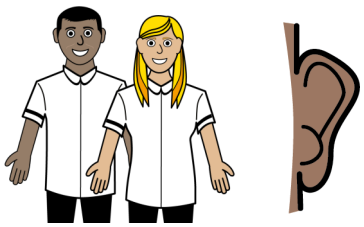
Do you have a hearing aid

Yes ☐ No ☐



If you ticked **yes** do you wear it

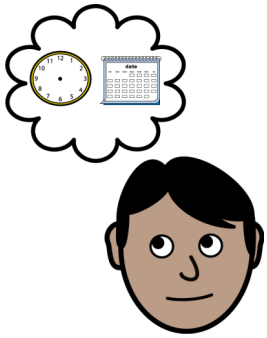
Yes ☐ No ☐



Do you visit an audiologist

Someone who helps with hearing and balance problems.

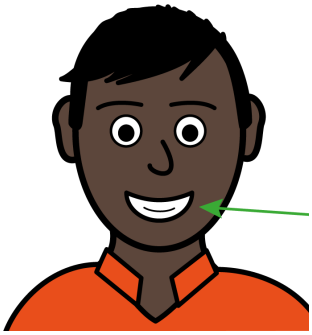
Yes ☐ No ☐



If you ticked yes what was the date of your last appointment

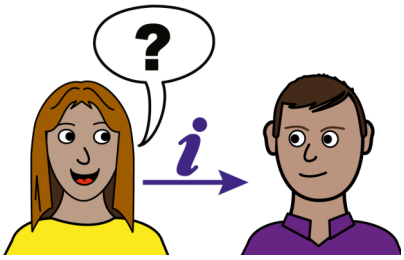
Day Month Year

Your teeth



Do you have any problems with your teeth gums or mouth

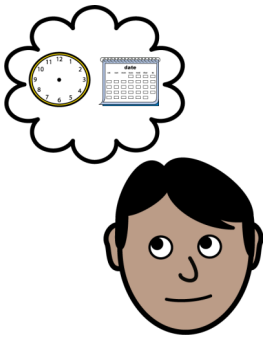
Yes ☐ No ☐



If you ticked **yes** what

Do you visit the dentist regularly

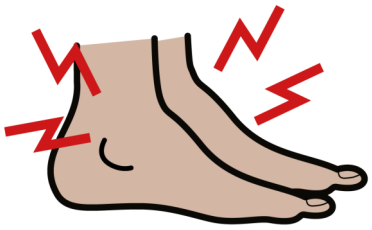
Yes ☐ No ☐



If you ticked **yes** what was the date of your last appointment

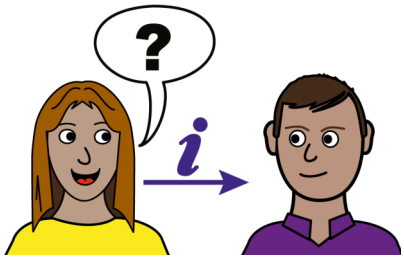
Day Month Year

Your feet

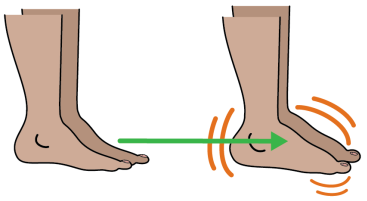


Do you have any problems with your feet

Yes ☐ No ☐

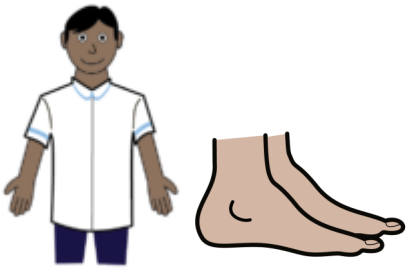


If you ticked **yes** what



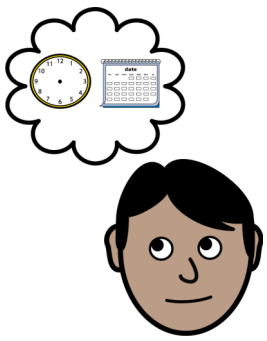
Do you have any swelling of your ankles or feet

Yes ☐ No ☐



Do you visit the podiatrist or chiropodist someone who can help with foot problems

Yes ☐ No ☐



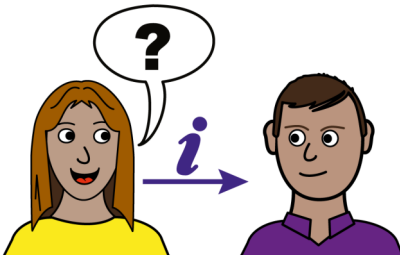
If you ticked **yes** what was the date of your last appointment

Day Month Year

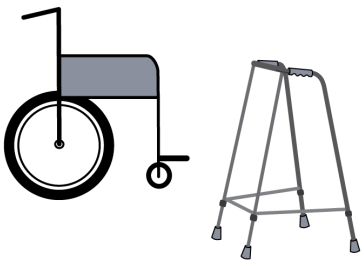
Your mobility

Are you able to move around easily

Yes ☐ No ☐



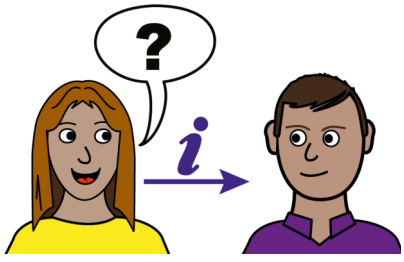
If you ticked **no** tell me more



Do you use mobility aids

This could be a stick, a frame or a wheelchair

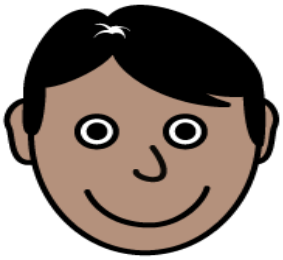
Yes ☐ No ☐



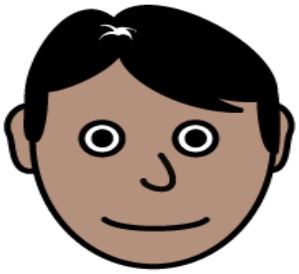
If you ticked **yes** what do you use

Your mobility

Has your mobility changed in the last year

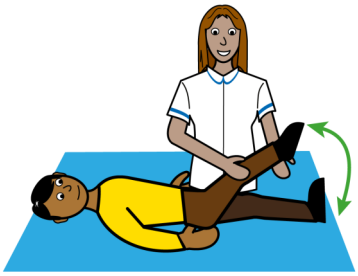


☐ It is better



☐ It is the same

☐ It is worse

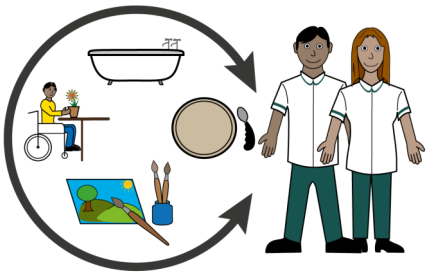


Do you see a physiotherapist

A physiotherapist works with you to help with problems that affect your movement

Yes ☐ No ☐

Your mobility



Do you see an occupational therapist

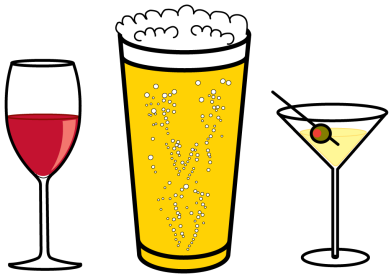
Occupational therapists help people to do everyday activities like bathing, eating and cooking

Yes ☐ No ☐

Exercise

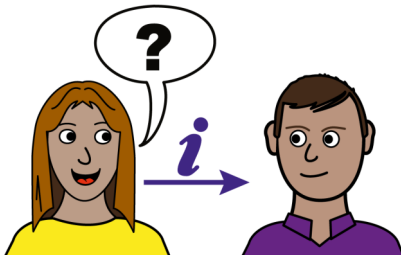
What exercise do you do

Alcohol



Do you drink alcohol

Yes ☐ No ☐



If you ticked **yes** how much do you drink

_____ Units a week

Example of units in different drinks

Pint of lager

2.6 units

175ml glass of wine

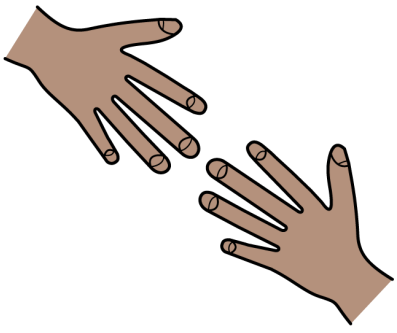
2.3 units

25 ml of spirit

1 unit

275 ml of alcopop

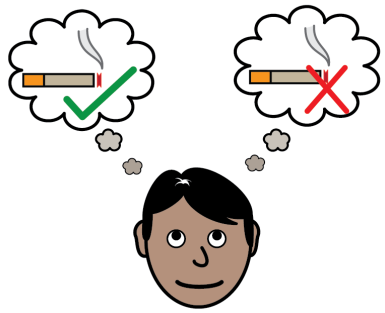
1.1 units



Do you want help to drink less alcohol

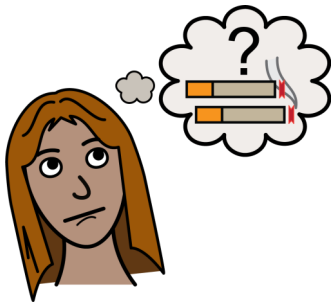
Yes ☐ No ☐

Smoking



Do you smoke

Yes ☐ No ☐



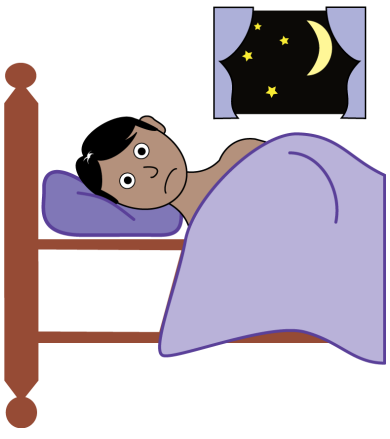
If you ticked **yes** how many

A day

Do you want help to stop smoking

Yes ☐ No ☐

Your sleep



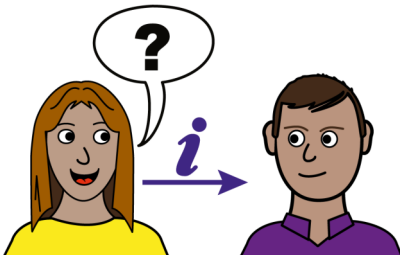
Do you have problems sleeping

Yes ☐ No ☐

Tablets and medicines

Do you take any tablets or medicines that are not from your doctor Things like vitamins painkillers or laxatives

Yes ☐ No ☐

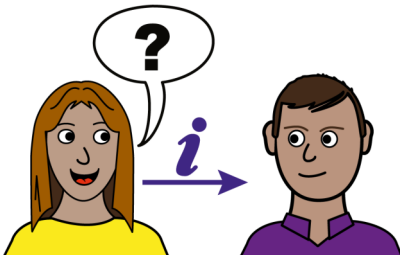


If you ticked **yes** what do you take

Allergies

Do you have any allergies

Yes ☐ No ☐

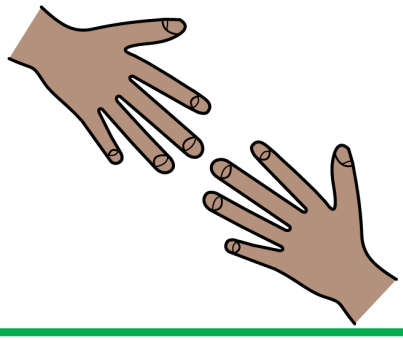


If you ticked **yes** what

Drugs

Do you use any drugs like cannabis or ecstasy

Yes ☐ No ☐



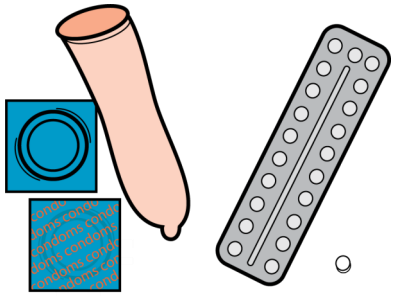
If you ticked **yes** do you want help to stop using these dugs

Yes ☐ No ☐

Sex

Do you have sex

Yes ☐ No ☐

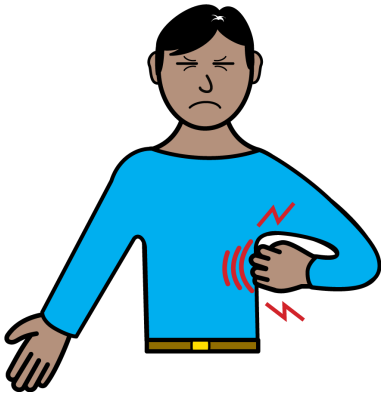


Do you use contraceptives

These help to stop a woman getting pregnant

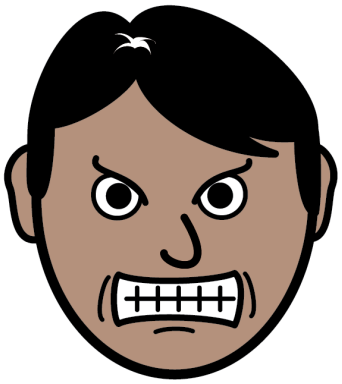
Yes ☐ No ☐

Your mental health



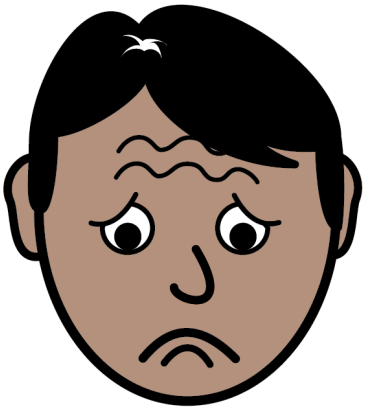
Do you try hurt yourself

Yes ☐ No ☐



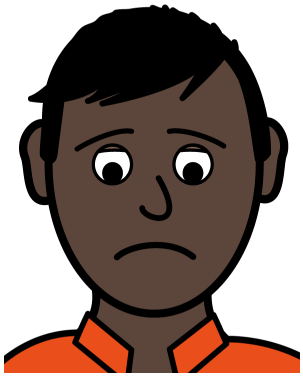
Do you get angry and shout at people a lot

Yes ☐ No ☐



Do you feel anxious and worried a lot of the time

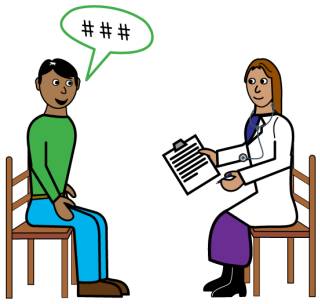
Yes ☐ No ☐



Do you feel sad a lot of the time and find it hard to cheer yourself up

Yes ☐ No ☐

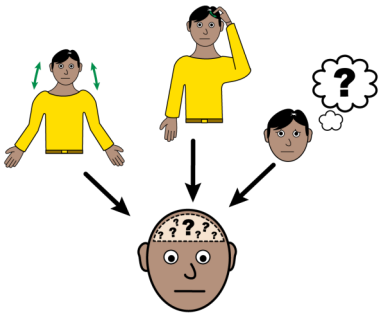
Your mental health



Do you see a psychiatrist

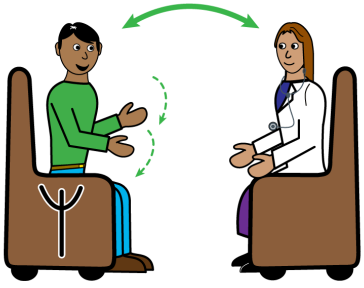
This is someone who helps people with mental health problems autism and epilepsy

Yes ☐ No ☐



Do you or your carer think there has been a change in your memory

Yes ☐ No ☐



Do you see a psychologist

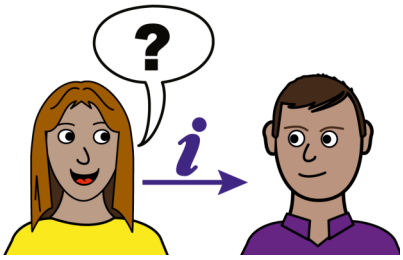
This is someone who helps you to understand your thoughts and feelings

Yes ☐ No ☐

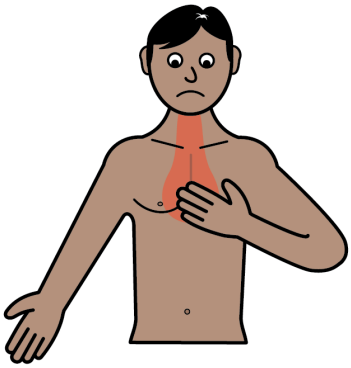
Your diet

Do you find it difficult to eat, drink or swallow

Yes ☐ No ☐



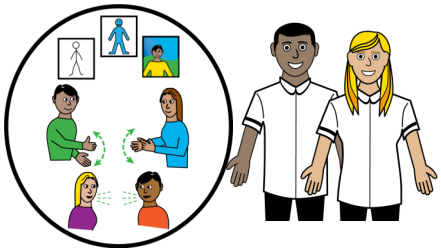
If you ticked **yes** what helps you to eat, drink or swallow



Do you have any burning pain in the center of your chest This might be heartburn or indigestion

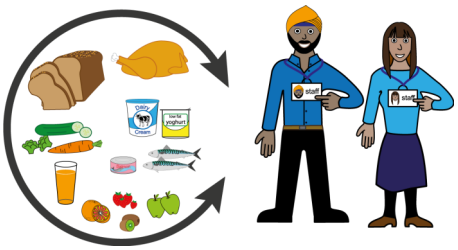
Yes ☐ No ☐

Your diet



Do you see a speech therapist to help you with eating and drinking

Yes ☐ No ☐

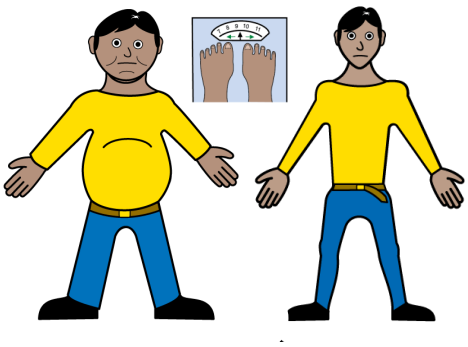


Do you see a Dietician

Yes ☐ No ☐

Has your appetite changed recently Are you eating a lot more or a lot less than normal

Yes ☐ No ☐



Are you worried about your weight Putting on or losing too much weight

Yes ☐ No ☐

Continence

Do you have constipation or diarrhoea. Constipation is when your poo doesn't come out easily or regularly and diarrhoea is when your poo is runny and comes very quickly

Yes ☐ No ☐

Does it hurt when you wee?

Yes ☐ No ☐

Is there any blood in your wee

Yes ☐ No ☐

Do you have any other problems when you wee
Like needing to wee a lot

Yes ☐ No ☐

Continence

Do you have any problems with urinary incontinence This means you can not control when you wee

Yes ☐ No ☐

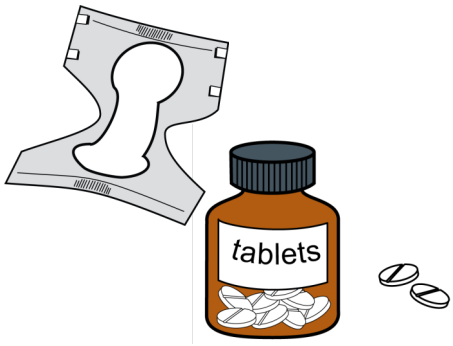
Do you have any problems with faecal incontinence. This means you can not control when you poo.

Yes ☐ No ☐

Do you see a continence nurse. This is someone who can help you if you can not control when you go to the toilet

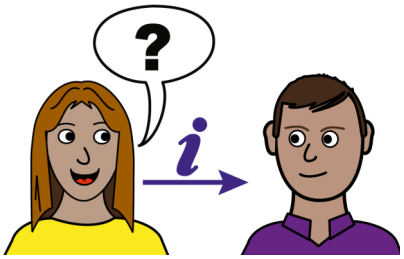
Yes ☐ No ☐

Continence



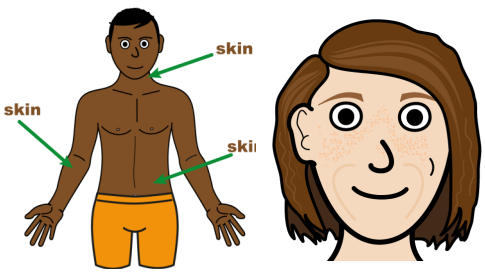
Do you have continence aids or medicine This is things like pads or medication

Yes ☐ No ☐



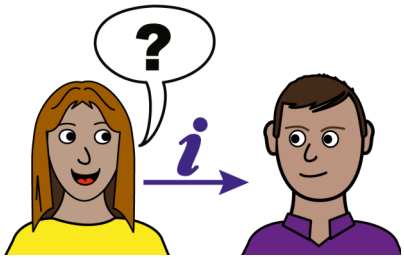
If you ticked **yes** what do you have

Hair skin and nails



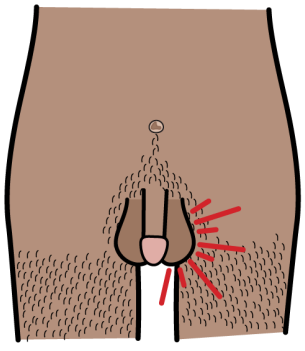
Do you have any problems with your hair, skin or nails

Yes ☐ No ☐



If you ticked **yes** what problems do you have

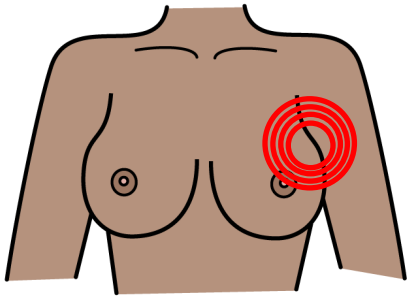
For men



Has there been any pain or swelling in your testicles

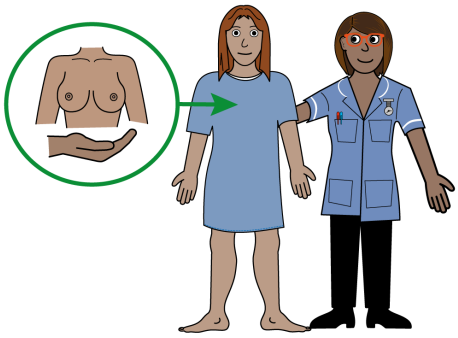
Yes ☐ No ☐

For women



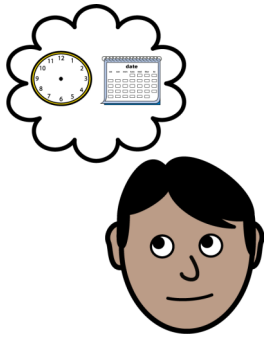
Have you noticed any pain or lumps in your breasts

Yes ☐ No ☐



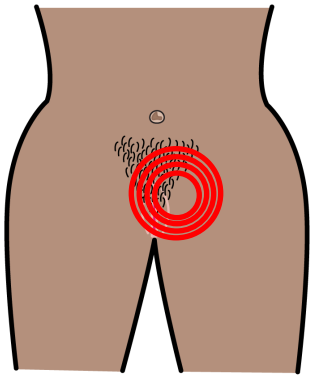
If you are over 50 have you been for a breast screening test

Yes ☐ No ☐



If yes when was your last test

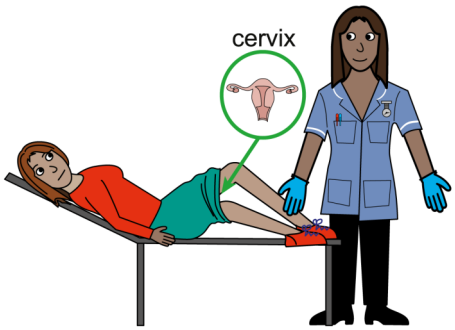
Day Month Year



Do you have any vaginal discharge that is smelly or makes you sore

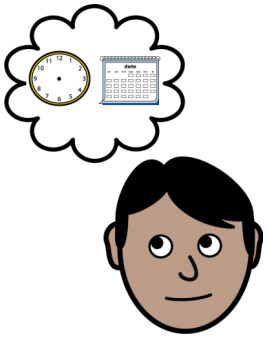
Yes ☐ No ☐

For women



If you are aged 25 to 64 have you had a cervical smear test

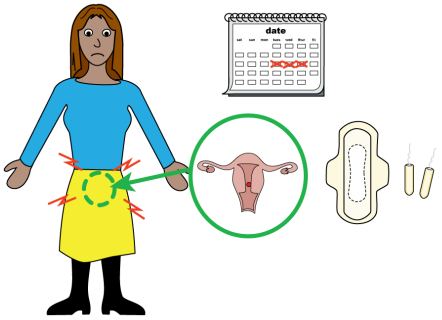
Yes ☐ No ☐



If **yes** when was your last test

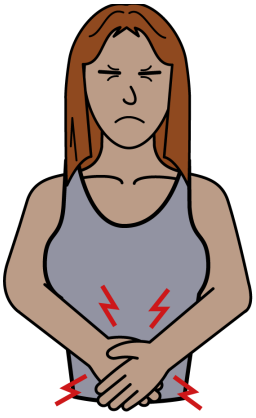
Day Month Year

For women - periods



Do you have periods

Yes ☐ No ☐



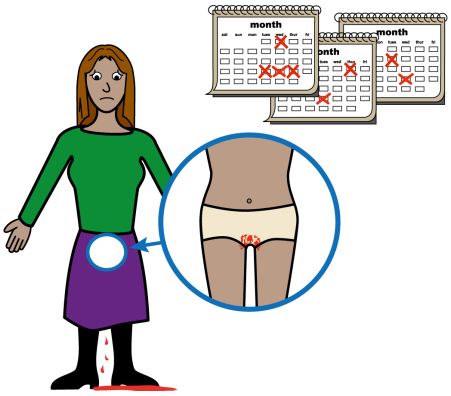
Are your periods painful?

Yes ☐ No ☐

For women - periods

Is the bleeding very heavy

Yes ☐ No ☐

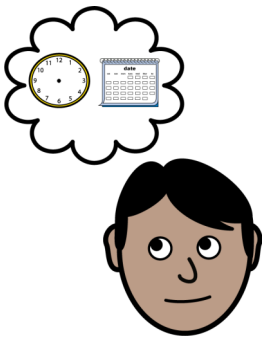


Is there any irregular bleeding Bleeding in between periods

Men and women aged 60 - 69

If you are aged between 60 and 69, have you been sent a kit to test for bowel cancer

Yes ☐ No ☐



If **yes** when did you last do the test

Day Month Year

Epilepsy

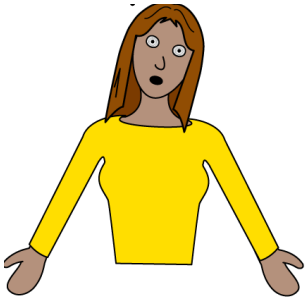
Do you have epilepsy

Yes ☐ No ☐

If you ticked **yes** do you know which type of epilepsy you have

In the last year have you started to shake or have movements that you can not control

Yes ☐ No ☐



Has your carer noticed that sometimes you are not concentrating You go blank and you cant see or hear them

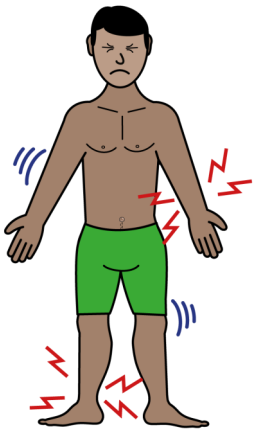
Yes ☐ No ☐

Epilepsy

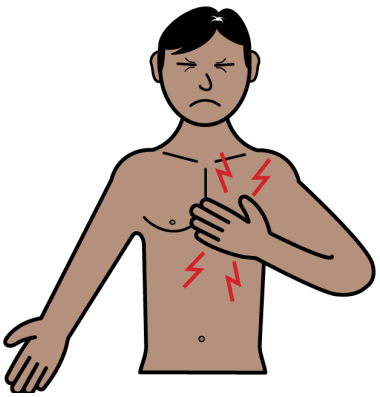
Do you see a specialist doctor or nurse about your epilepsy

Yes ☐ No ☐

Pain



How would someone know if you are in pain

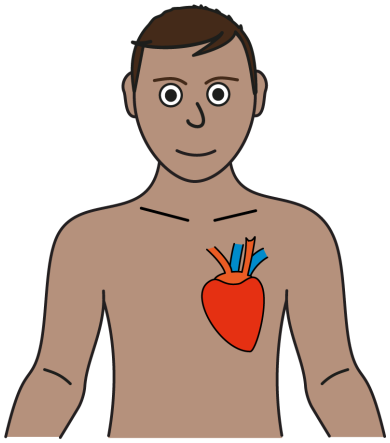


Do you get any pain in your chest

Yes ☐ No ☐

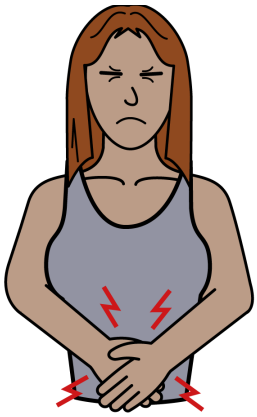
If **yes** when does the pain happen maybe after exercise

Pain



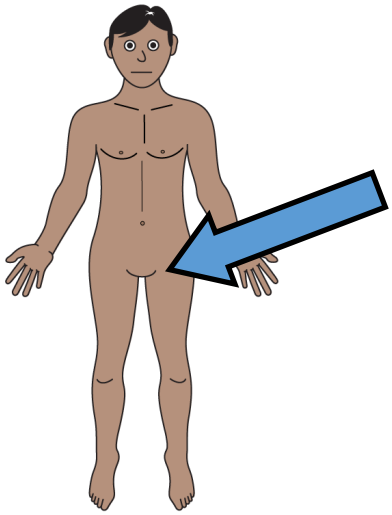
Do you feel you have an uneven heart beat or your heart is beating fast

Yes ☐ No ☐



Do you have any pain in your abdomen Your tummy

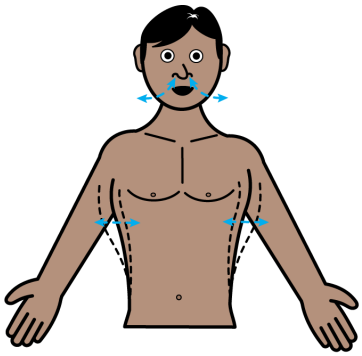
Yes ☐ No ☐



Have you got any swellings in your groin Just above the crease at the top of your legs

Yes ☐ No ☐

Breathing



Do you have any problems with your breathing

Yes ☐ No ☐

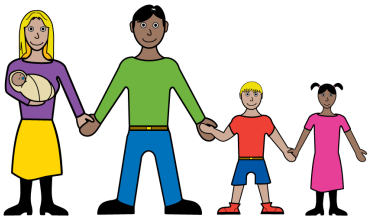
Do you cough

Yes ☐ No ☐

Do you cough anything up

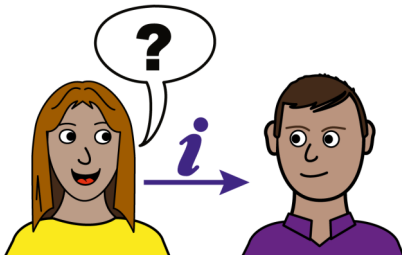
Yes ☐ No ☐

Family



Are there any medical problems or illnesses that run in your family

Yes ☐ No ☐



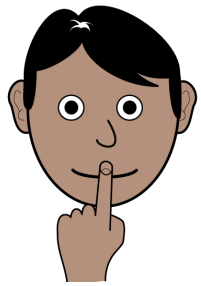
If **yes** what illnesses

Any other health conditions?

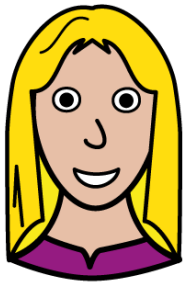
Do you have any other health conditions If you don't have any leave the box blank

Ethnicity

What is your ethnic background



I'd prefer not to say ☐



White

☐ English ☐ Scottish ☐ Welsh

☐ Northern Irish ☐ Irish ☐ Gypsy or Irish Traveller

☐ Any other White background

Ethnicity

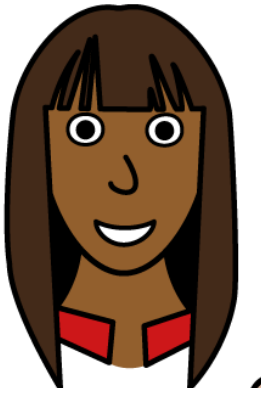
Mixed race

☐ White and Asian

☐ White and Black

☐ White and black African

☐ Any other mixed background



Asian or Asian British

☐ Indian

☐ Chinese

☐ Pakistani

☐ Bangladeshi

☐ Any other Asian

Ethnicity

Black or Black British

☐ African ☐ Caribbean

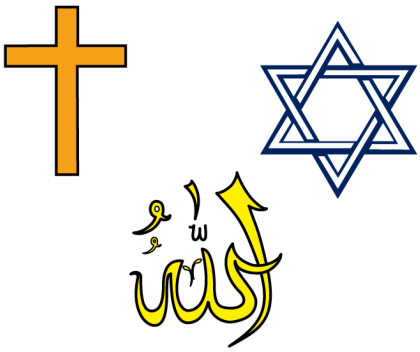
☐ Any other Black background

Other Ethnic Group

☐ Arab

☐ Any other Ethnic background

Religion



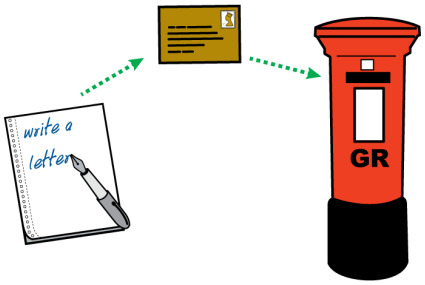
What is your religion

☐ No religion ☐ Christian ☐ Buddhist

☐ Hindu ☐ Jewish ☐ Muslim

☐ Sikh ☐ Any other religion

Thank you for filling in this questionnaire



Now send it back to your doctor

Do you have a Health Action Plan

Yes ☐ No ☐

If you ticked **yes** bring it to your Health Check

We look forward to seeing you at your health check