**My Health**

**Questions**

**For individuals with**

**a Learning Disability**

**For professional use**

**Confidential**

Name: ………………….……. Date of Birth: …. / …. / ……

NHS Number: ………………………………………….

Today’s date: ......./......../........... Completed by: …………………

**Allergies**

**ARE EMERGENCY CONTACT DETAILS UP TO DATE**

Updated 17/12/2019

**Capacity /Consent**

Capacity **Yes / No**

Who is here to support the patient?

Ok to share patient information **Yes / No**

**PLEASE CONSIDER ANY SPECIFIC TESTS RELATING TO THE PERSONS DISABILITY. For Example: Dementia screening or thyroid testing for those with Downs Syndrome.**

**Support and Patient Information**

Do you see any health professionals? **Yes / No**

Who?

Do you have a Social Worker? **Yes / No**

**IS THERE ANYTHING FROM RECENT LETTERS OR LAST YEAR’S HEALTH CHECK? PLEASE CHECK**

Have you had a health check before? **Yes / No**

Do you have actions from my health check? **Yes / No**

Is there anything outstanding? **Yes / No**

Are you worried about anything?

**14-17 year olds only**

Where do you go to School?

Do you have a statement of educational needs?

Is the patient currently under transition from Child to Adult services? Do you need to start this process? Refer to CAMHS if needed.

**Immunisations**

Are you up to date with immunisations?

**Date of last flu jab………………………………………………………………………....**

Tetanus **Yes / No** MMR **Yes / No**

Polio (if needed) **Yes / No** HPV (if needed) **Yes / No**

Hepatitis B **Yes / No** Pneumococcal Vaccination **Yes / No**

Individuals in shared accommodation require Hepatitis B vaccine. Can any of the immunisations be given now? If not – please document on actions from my health check.

**Reasonable Adjustments**

Does this patient need more time for appointments?

Consider correct environment?

Extra support with communication, such as easy read?

Does the patient need an appointment at a specific time of day?

Preferred method of communication, such as makaton?

**Functional life skills**

**Mobility**

Any permanent physical disability? **Yes / No**

Any problems with your joints, moving or co-ordination? **Yes / No**

Any problems with posture, standing or spinal curvatures? **Yes / No**

Consider osteoarthritis, pain relief, vitamin D levels.

Any tremors or shaking? **Yes / No**

Do you use any mobility or positioning aids or equipment? **Yes / No**

Does anyone help you with your personal care? **Yes / No**

Refer to GP, Physiotherapists, OT, Community Learning disability team or Primary Care Liaison Nurses for additional support. For patients with Profound Multiple Learning Disability (PMLD) please refer to Community Learning Disability Team for annual assessment and information sharing.

**Daily Living Skills – discuss any problems or support needed with:**

Eating Hydration

Dressing Ability Bathing

Toilet Dependency Daily Living Support

Consider a referral to adult social care 0300 1234 131

**Lifestyle and health promotion**

**Diet**

Do you need a special diet? **Yes / No**

What would you normally eat for Breakfast, Lunch, Tea

Does patient require a referral to health promotion (01209) 615600

**Exercise**

What activities do you do?

Consider leaflet on healthy living and exercise. www.easyhealth.org.uk

**Smoking**

Do you smoke? **Yes / No**

How many cigarettes do you smoke a day?

Would you like help to stop smoking? **Yes / No**

Does patient require a referral to the stop smoking service?

**Alcohol and substance misuse**

Do you drink alcohol? **Yes / No**

What do you drink?

How many glasses?

How often do you drink alcohol?

Do you take any drugs?

**RELATIONSHIPS:**

Do you have a partner? **Yes / No**

Have you ever had sex with anyone? **Yes / No**

Do you know about contraception? **Yes / No**

Do you know about how people get pregnant? **Yes / No**

Do you know about sexual diseases? **Yes / No**

Would like any information on these issues? **Yes / No**

Would you like to talk to someone? **Yes / No**

Do you know it is okay to say **‘NO’** if you don’t want to have sex or be touched? **Yes/ No**

Do you know you must listen and stop if someone else says ‘**NO**’? **Yes / No**

**EASY READ INFORMATION AVAILABLE AT:**

[www.apictureofhealth.southwest.nhs.uk](http://www.apictureofhealth.southwest.nhs.uk)

[www.easyhealth.org.uk](http://www.easyhealth.org.uk)

**Female screening**

Have you noticed any problems or changes with your breasts or nipples? **Yes / No**

Do you check your breasts every month? **Yes / No**

(47+) Have you had your breast screening? **Yes / No**

Have you ever had a smear test? **Yes / No**

(25+) Are you due a smear test? **Yes / No**

Easy read information available at [www.easyhealth.org.uk](http://www.easyhealth.org.uk)

**REFER TO LEARNING DISABILITY SCREENING LIAISON NURSE FOR SUPPORT IF NEEDED**

**HEIGHT AND WEIGHT:**

Current height: Current weight:

Waist measurement: Blood Pressure: ….. / …..

**EYES AND VISION:**

Any problems with your eyes? **Yes / No**

Any pain or itching? **Yes / No**

Do you wear glasses? **Yes / No**

When did you last have an eye test? Date…………………………………………………………………

(Routine tests should be done every two years)

If you have Diabetes have you been for Retinal Screening in the last year (as well as an eye test)

**EARS AND HEARING:**

Do you have a hearing or ear problems?

**PLEASE CHECK EVERYONES EARS.**

**MOUTH AND TEETH:**

Name of Dentist:

When was the last time you visited the dentist?...........................................................................

Any problems with your mouth, teeth or gums? **Yes / No**

Do you have difficulty eating or chewing? **Yes / No**

Do you think you have bad breath? **Yes / No**

Do you have any problems with dribbling? **Yes / No**

Do you ever get mouth ulcers or cold sores? **Yes / No**

Consider referral to Community Dental Service if patient is not able to manage mainstream dentist-Email [kccg.rmcdentalreferrals@nhs.net](mailto:kccg.rmcdentalreferrals@nhs.net) **-**Tel: 0333 405 0290

CONSIDER SALT REFERRAL.

**BREATHING**

Do you have any problems with your breathing? **Yes / No**

Do you get short of breath? **Yes / No**

Do you have a cough that is not getting better? **Yes / No**

Do you bring up mucous or phlegm? **Yes / No**

Do you have any blood in your spit? **Yes / No**

**Gastro – Intestinal**

Do you have any problems eating or swallowing? **Yes / No**

Do you cough when you eat and drink? **Yes / No**

Do you cough after you eat and drink? **Yes / No**

After eating do you any pain? **Yes / No**

If yes to any of the above please consider a SALT referral.

**Having a poo**

Do you ever get tummy/stomach pains? **Yes / No**

Do you have any pain when you go to the toilet? **Yes / No**

Do you ever find it difficult to poo (constipation)? **Yes / No**

Do you ever have very loose poo (diarrhoea)? **Yes / No**

Have you seen any blood, jelly or black in your poo? **Yes / No**

OVER 60’s: Have you done your bowel screening? **Yes / No**

**Refer to Screening liaison nurse if bowel scope screening not complete (offered once at age 55) or bowel screening (60 -75 years, invited every 2 years).**

**Having a pee**

Do you have any problems when you go for a pee? **Yes / No**

Have you had your pee tested recently? **Yes / No**

Do you ever find it hard to go? **Yes / No**

Is your pee a dark colour? **Yes / No**

Does your pee smell? **Yes / No**

Do you find that you need to go for a pee more often? **Yes / No**

Do you ever have any accidents with your pee in the day or night (wet the bed)? **Yes / No**

Do you wear pads? **Yes / No**

If yes where do you get them?

**Consider a referral to the community nursing team for incontinence product or the continence service.**

**Women’s health**

Do you have periods? **Yes / No**

Do you have any problems with them? **Yes / No**

Have you been through ‘The Change’ (menopause)? **Yes / No**

Are you having any problems with this? **Yes / No**

**Epilesy**

Do you have any kind of epilepsy? **Yes / No**

Do you or someone else write down when you have a seizure? **Yes / No**

Do you have an epilepsy nurse? **Yes / No**

**Central Nervous System**

Have you been seen in neurology? **Yes / No**

Date of appointment

Any changes in how you feel things?

Have you had any fits? **Yes / No**

**Cardiovascular system**

Any heart problems or chest pain? **Yes / No**

Any problems with your breathing or a cough? **Yes / No**

Do you bring up mucous or phlegm? **Yes / No**

Do your ankles swell? **Yes / No**

STAFF: (MEN AGED 65) REFER TO LEARNING DISABILITY SCREENING LIAISON NURSE

FOR ‘AAA’ SUPPORT IF NEEDED

Diabetes - When was patients last HbA1c if not within the last 12 months consider a recheck.

**Muscoskeletal** – Is the patient at risk of Osteoporosis? Yes No – Please give posture advice.

**Feet**

Are you having any problems or pain with your feet? **Yes / No**

Do you need any special footwear? **Yes / No**

Who cuts your toenails?

Do you ever see a chiropodist or podiatrist? **Yes / No**

When?

Name of Chiropodist / Podiatrist:

**MENTAL HEALTH**

Do you sleep well at night? **Yes / No**

If not do you know why? Explain:

How are you feeling?

Is anything worrying or upsetting you? **Yes / No**

Do you have someone you can talk to about things? **Yes / No**

Any behaviour that you have, which is a problem for you or anyone else? (self-harm, aggression, rituals, etc) **Yes / No**

Do you seem more confused or forgetful? **Yes / No**

Consider early onset dementia particularly in Down Syndrome or referral to outlook southwest.

**Examination and measurements**

**Please complete a physical examination**

Pulse rate Heart sounds

Digestive system Skin

Pressure areas Breast

Female pelvis (if needed)

**Latest results**

HbA1c Serum Cholestrol

Full blood count Serum HDL cholesterol levels

Thyroid function test Urea and electrolytes

Liver function test

Urine dipstick

**Please repeat bloods if patient requires them.**

Lithium and anti-epilepsy drug levels Vitamin D if on AED

FSH in prolonger amenorrhoea PSA (if indicated)

Stool H pylori antigen (if indicated) CRP (if indicated)

**Medication**

|  |  |  |
| --- | --- | --- |
| Name | Dosage | What do you take it for? |
|  |  |  |

Are you worried about any of your medication? **Yes / No**

Do you take any over-the-counter medicines? **Yes / No**

**Please use STOMP to review any patient taking more than 2 anti-psychotic medications.**

**End of life care**

Has advanced care planning been considered? **Yes / No**

Is patient on the gold standard framework? **Yes / No**

**Any safeguarding concerns?**

**Patient’s goals**

**With thanks to Cornwall Partnership NHS Foundation Trust**

**ACTIONS FROM MY HEALTH CHECK (Copy to be given to patient)  
  
YOUR NAME: …………………………………………………**

|  |  |  |
| --- | --- | --- |
| BPwoman2 | Date of Health Check:  Done by:  My height:  My Weight:  My Blood Pressure:  Date for next Check: | My Primary Care Liaison Nurse is:  Phone Number: |
| GP1 | Do I need to see my doctor?  When and why: | |
| Diabetes_nurse1 | Do I need to see anyone else?  Who and Why: | |
| Social_worker2 | Health advice given: | |
| Dont_know_man2 | Anything else I need to know? | |