Resource 20

easy read

NHS
Norfolk and Waveney
Integrated Care Board

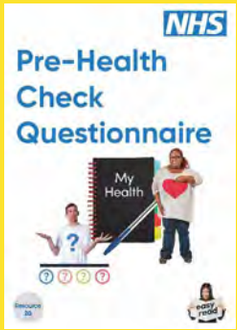
Pre-Health Check Questionnaire

- **Please keep this and use at future annual health check appointments.**
- **You can fill this out on a computer, please see the back cover for details.**

Print version

Ace Anglia

About this booklet



Please fill in this booklet before you come to your Annual Health Check. You may want to ask for help from family, a friend, or a support worker.

All sections are optional to fill in, the information will then be transferred to your confidential health record

Please bring any charts you or your staff use to monitor your health.

For example, sleep charts, bowel charts, period charts, seizure charts.

Please bring your Health Action Plan, if you have one.

Please also bring a urine (wee) sample. You may need to pick up a pot from your surgery.

What is the date of your Health Check?

DAY	**MONTH**	**YEAR**

About me

Name

Date of birth

DAY **MONTH** **YEAR**

Telephone number

Email Address

About me

Address

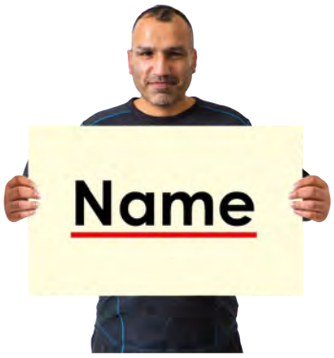
Were you born a

○ Male ○ Female

What would you describe your gender as?

What is your ethnicity?

About me



Emergency Contact/Supporter name

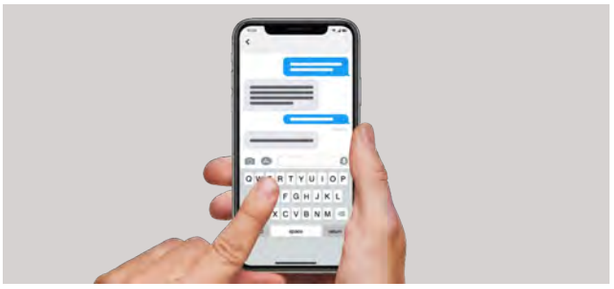
Emergency Contact/Supporter telephone number

Emergency Contact/Supporter email address

About me

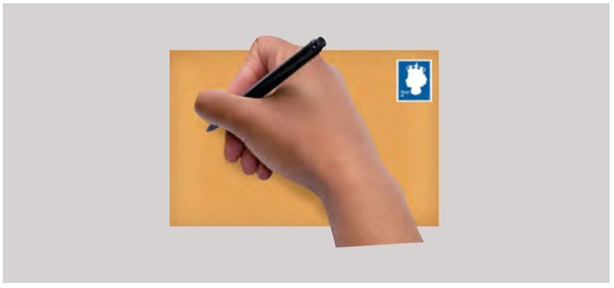
How do I like to be contacted?

Phone call



Text message

Email



Letter

Other
Please write in the box

Would you like to be contacted in easy read?

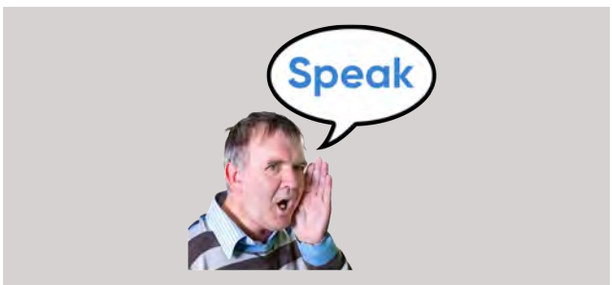
Yes

No

My Communication

The languages I used to talk to people:

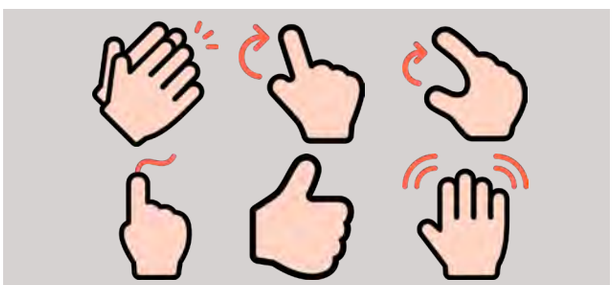
How do you communicate and understand others?
(tick as many as you like)?



☐ **Talking**

☐ **Signing or Makaton**

☐ **Using a communication aid**



☐ **Pointing and gestures**

☐ **Using symbols, pictures or photos**

☐ **Other**
Please write in the box

My Communication

Can you easily tell people if you are ill or in pain?

Yes ☐ No ☐

If no, is this written in a support plan?

Yes ☐ No ☐

Do you see, or have you seen, a speech therapist to help with your communication?

Yes ◯ No ◯

If yes, when was the date of your last appointment?

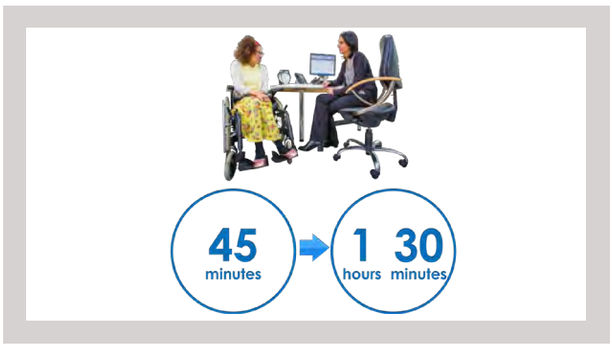
Do you have any difficulty in communicating?

Yes ◯ No ◯

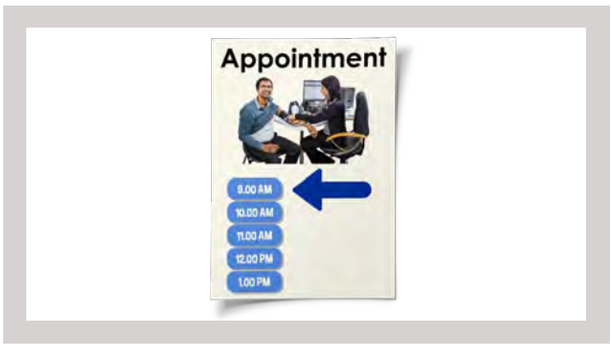
If yes, what helps you to communicate?

Reasonable adjustments

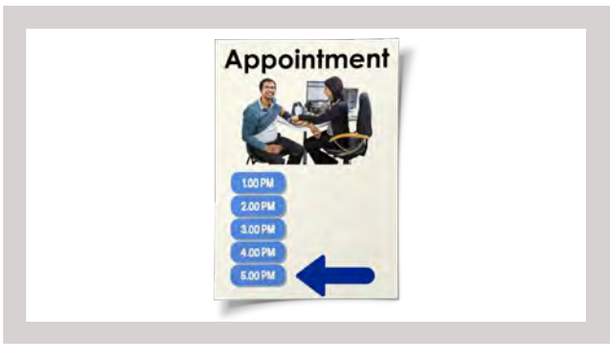
How can your GP practice help you go to your annual health check?



☐ **Longer appointment**



☐ **First appointment of the day**



☐ **Last appointment of day**

☐ **Pictures to help me understand**

☐ **Other**
Please write in the box

Reasonable adjustments

Would you like someone to attend your annual health checks with you?

Yes ◯ No ◯

If yes, who would you like to attend with you?

☐ **Family member**

☐ **Friend**

☐ **GP staff member**

☐ **Support worker or carer**

How would you like them to be involved?

My diet

Do you have any difficulties eating or drinking?

Yes ○ No ○

If yes, what helps you eat, drink or swallow?

Do you see a speech therapist for swallowing?

Yes ○ No ○

Do you have any burning pain in your chest (heartburn or indigestion)?

Yes ○ No ○

My diet

Please write below what foods and drink you like:

Breakfast

Lunch

Dinner

Snacks

Do you cough when you eat or drink?

Yes ◯ No ◯

Have you had any chest infections in the last 6 months?

Yes ◯ No ◯

If yes, how many?

Are you eating more or less than you used to?

More ○ Less ○

Do you see a dietician?

Yes ○ No ○

Weight & appetite

Are you worried about your weight?
(either putting on too much weight or losing weight)?

Yes ○ No ○

Exercise

What exercise do you do?

Drinks

Examples of drinks. Please tick what you drink

Water, squash or juice

☐

Tea, coffee or hot chocolate

☐

Fizzy drinks

☐

Energy Drinks

☐

What else do you drink?

How many drinks do you drink a day?

drinks a day

Alcohol

Do you drink alcohol?

Yes ◯ No ◯

Examples of alcoholic drinks. Please circle what you drink

Beer

Wine

Spirit

Alcopop

If yes, what do you drink?

How often?

Every Day ◯ Once a Week ◯ Once a Month ◯

Do you want help to drink less alcohol?

Yes ◯ No ◯

My breathing

Do you have any problems with your breathing?

Yes ○ No ○

Do you cough?

Yes ○ No ○

If yes, do you cough up anything?

Yes ○ No ○

If yes, what do you cough up?
And how often?

Smoking

Do you smoke?

Yes ○ No ○

If yes, how many cigarettes do you smoke a day?

Do you vape?

Yes ○ No ○

If you smoke or vape, would you like help to stop?

Yes ○ No ○

Where I live

Please tell us about where you live.

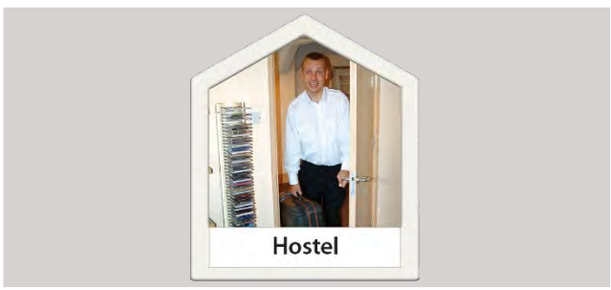
What kind of place is it?

Your family home

A residential care home

Your own flat or house

Supported living home



Hostel

Homeless

Employment

Do you have a job? Part time or full time

Yes ◯ No ◯

If yes, what is your job? Is it paid or unpaid?

Education

Do you go to school or college?

Yes ◯ No ◯

If yes, what school or college do you go to?

Do you have an education health and care plan (EHCP)?

Yes ◯ No ◯ Don't know ◯

My care and support

If you have support, who supports you (if you don't have any support, leave the boxes blank)?

Family

Name of family carer

Family carer's contact number

Family carer's e-mail address

My care and support

Paid support worker / carer

Name of support worker

Support worker's organisation

Organisation's phone number

Organisation's e-mail address

Social worker (if you have one)

Name of social worker

My care and support to others

Are you a carer for anyone (this could be for children, parents or a partner)?

A carer is anyone who looks after someone who needs help and cannot cope without their support. The care is unpaid.

Yes ○ No ○ Prefer not to say ○

If yes, who do you care for?

If you care for someone, have you had a carer's assessment

Yes ○ No ○

My teeth

Do you have any problems with your teeth, gums or mouth?

Yes ○ No ○

If yes, what?

Do you have a dentist that you are registered with?

Yes ○ No ○

If Yes which dentist do you go to?

Do you go to the dentist regularly?

Yes ○ No ○

What was the date of your last dental appointment?

DAY MONTH YEAR

My eyesight

My vision

Do you have any problems with your eyes or difficulty seeing things?

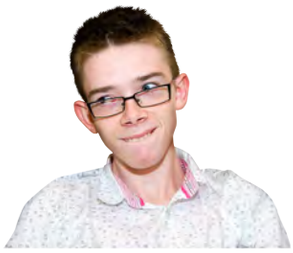
Yes ○ No ○

What was the date of your last optician's appointment (if you are not sure, leave blank)?

DAY	MONTH	YEAR

Do you need glasses?

Yes ○ No ○



If yes, do you wear your glasses?

Yes ○ No ○

Do you wear contact lenses?

Yes ○ No ○

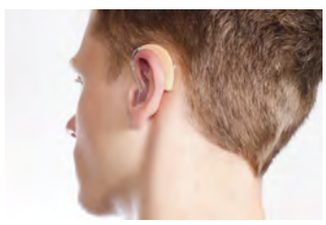
My hearing

Do you have any difficulty hearing?

Yes ○ No ○

Do you have a hearing aid?

Yes ○ No ○



If yes, do you wear it?

Yes ○ No ○

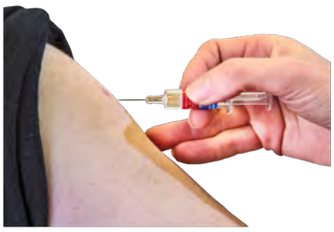
Do you visit an audiologist (someone who helps with hearing and balance problems)?

Yes ○ No ○

If yes, what was the last date of your last appointment?

DAY	MONTH	YEAR

Vaccinations



Have you had any of these vaccinations?

A vaccination is an injection that helps to protect from infectious diseases.

If you are unsure about dates, please leave blank and your doctor can help you fill it out.

Please tick Yes, No or Don't know

Flu Vaccination

Yes ◯ No ◯ Don't know ◯

If yes, what date?

Pneumonia Vaccination

Yes ◯ No ◯ Don't know ◯

If yes, what date?

Covid-19 Vaccination

Yes ◯ No ◯ Don't know ◯

If yes, what date?

Hepatitis B Vaccination

Yes ◯ No ◯ Don't know ◯

If yes, what date?

Vaccinations

Other,
Please write in box

Other vaccines you might have had:

- **Travel vaccines**
- **HPV**
- **HIV**
- **MMR**
- **Shingles**
- **RSV**
- **Childhood ones?**

Have you had any other vaccinations?

If yes, please write in the box

Some common bad reaction to vaccinations:

- **Itching**
- **Difficulty breathing**
- **Swelling of your face and throat**
- **A fast heartbeat**
- **A bad rash all over your body**
- **Dizziness and weakness**

Have you had a bad reactions to vaccinations in the past?

If yes, please write in the box

Screening

Are you diabetic?

Yes ○ No ○

If your answer was yes, have you had your diabetic eye screening test?

Yes ○ No ○

If yes, when did you last do the test?

DAY	MONTH	YEAR

Screening

Have you noticed any pain or lumps in your breasts?

Yes ○ No ○ I don't check ○

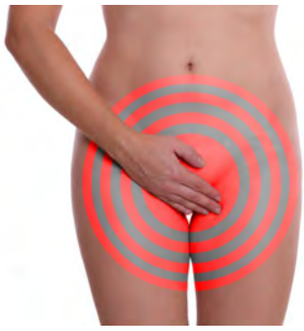
Have you been for a breast screening test?
(You will be invited for breast screening between 50 to 70 years old)

Yes ○ No ○

If yes, when was your last test?

DAY	MONTH	YEAR

Screening



Do you have any vaginal discharge (fluid) that is smelly or makes you sore?

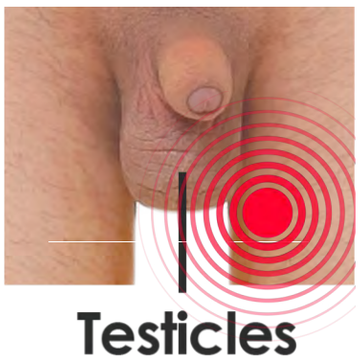
Yes ○ No ○

Have you had a cervical smear test?
(You will be invited for cervical smear test between 25 to 64 years old)

Yes ○ No ○

If yes, when was your last test?

DAY	MONTH	YEAR



Has there been any pain or swelling in your testicles?

Yes ○ No ○ I don't Check ○

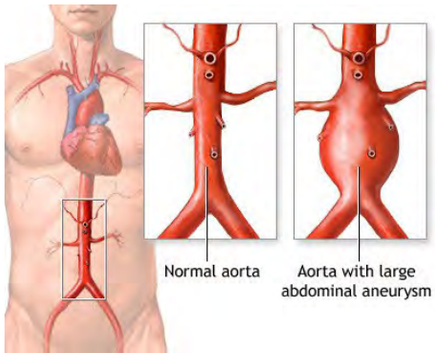
If you are aged 54 and over, please answer this question

If you are aged 54 or over, have you been sent a kit to test for bowel cancer?

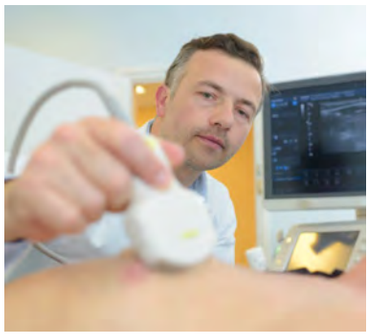
Yes ○ No ○

If yes, when did you last do the test?

DAY MONTH YEAR



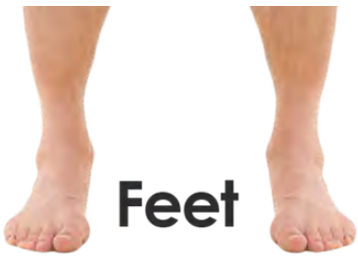
Abdominal Aortic Aneurysm: An abnormal bulging and weakening in your aorta as it goes through your tummy.



If you are 65 or over, have you been for an AAA (Abdominal Aortic Aneurysm) screening?

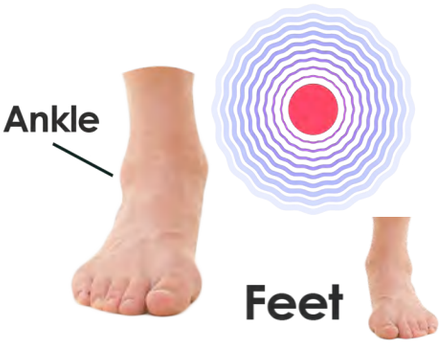
Yes ○ No ○

My feet



Do you have any problems with your feet?

Yes ○ No ○



Do you have swelling of your ankles or feet?

Yes ○ No ○

Do you visit the podiatrist or chiropodist (someone who can help with common foot problems)?

Yes ○ No ○

If yes, what was the date of your last appointment?

DAY MONTH YEAR

Who cuts your toenails?

Medical phobias / fears

Do you have any medical fears/worries?

Yes ◯ No ◯

If yes, what?

My Learning Disability

What type of learning disability do you have?

◯ **Mild** ◯ **Moderate**

◯ **Severe** ◯ **Profound**

◯ **Don't know**

Were you born with the learning disability or did something cause it (if you do not know, leave the box blank)?

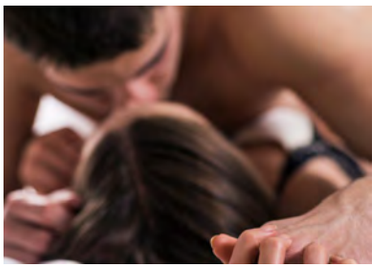
Hair, skin and nails

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

Yes ○ No ○

If yes, what?

Sex



Do you have sex?

Yes ○ No ○

Do you use contraceptives (These are things that stop a woman getting pregnant)?

Yes ○ No ○

Are you planning to have a baby?

Yes ○ No ○

Sex

Have you had a sexual health screening to check for viruses?

Yes ◯ No ◯

Drugs

Do you use drugs (for example cannabis or ecstasy)?

Yes ◯ No ◯

If yes, do you want help to stop using these drugs?

Yes ◯ No ◯

Memory

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

Yes ◯ No ◯

Medication

Do you take any tablets or prescribed medication from your doctor?

Yes ○ No ○

Do you take any tablets or medicines that are not from your doctor (things like vitamins, painkillers, laxatives)?

Yes ○ No ○

If yes, please write in this box what tablets or medicine do you take:

My allergies

Do you have any allergies?

Yes ○ No ○

If yes, what are you allergic to?

My mobility

Are you able to move around easily without pain?

Yes ○ No ○

Any comments about your mobility

Do you have mobility aids (these are things like a wheelchair, a stick, or a frame)?

Yes ○ No ○

If yes, what mobility aids do you have?

My mobility

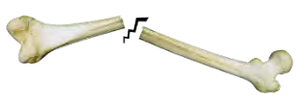
Do you still use them? Would you like a review?

Has your mobility changed in the last year?

It's better ○ It's the same ○ It's worse ○

Do you fall over a lot?

Yes ○ No ○



Have you broken any bones?

Yes ○ No ○

My mobility

Do you see a physiotherapist (physiotherapists work with people to help with a range of problems that affect your movement)?

Yes ○ No ○

What was the date of your last review?

DAY	MONTH	YEAR

Do you see an occupational therapist (occupational therapists help people of all ages to carry out everyday activities that are essential for health and wellbeing)?

Yes ○ No ○

What was the date of your last review?

DAY	MONTH	YEAR

Epilepsy

Have you had a seizure in the last year?

Yes ○ No ○

Have you seen epilepsy nurse in the last year?

Yes ○ No ○

My sleep

Do you have problems sleeping?

Yes ○ No ○

What time do you go to bed?

What time do you wake up?

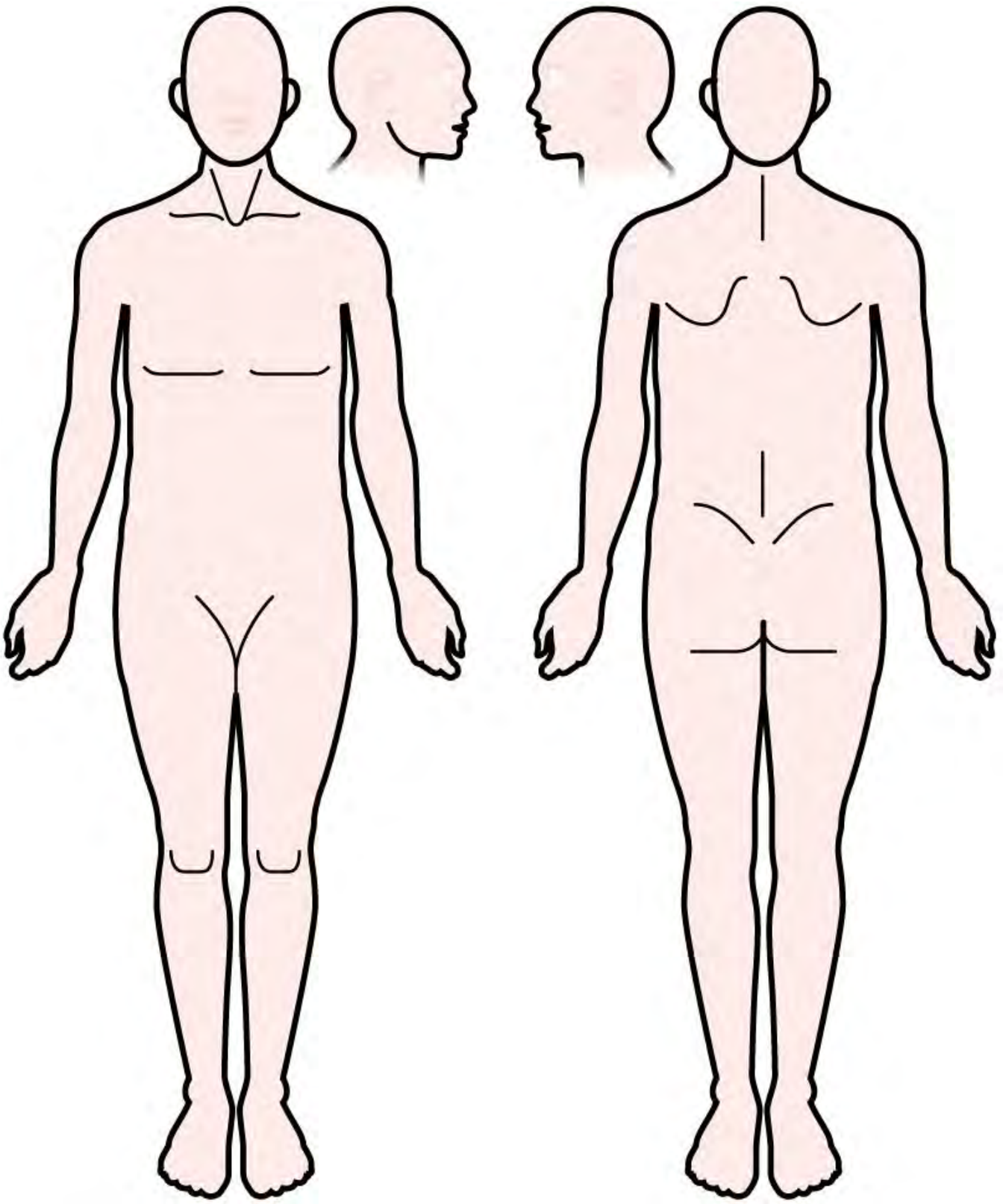
Does anyone tell you, you snore?

Yes ○ No ○

Pains

Please click or mark on the image where your pain is on the body

Clear



Continence

How many times a day do you have a poo?

What does your poo look like?

Type 1: Severe constipation
Separate, hard lumps

Type 2: Mild constipation
Lumpy and sausage like

Type 3: Normal
A sausage-shape with cracks in the surface

Type 4: Normal
Like a smooth, soft sausage or snake

Type 5: Lacking fibre
Soft blobs with clear-cut edges

Type 6: Mild diarrhoea
Mushy consistency with ragged edges

Type 7: Severe diarrhoea
Liquid consistency with no solid pieces

Continence

Do you have any constipation or diarrhoea?

Yes ○ No ○

Do you have any problems pooing?

For example, having an accident.

Yes ○ No ○

Poo

Do you have any problems with weeing?

For example, having an accident.

Yes ○ No ○

Wee

Does it hurt / burn when you wee?

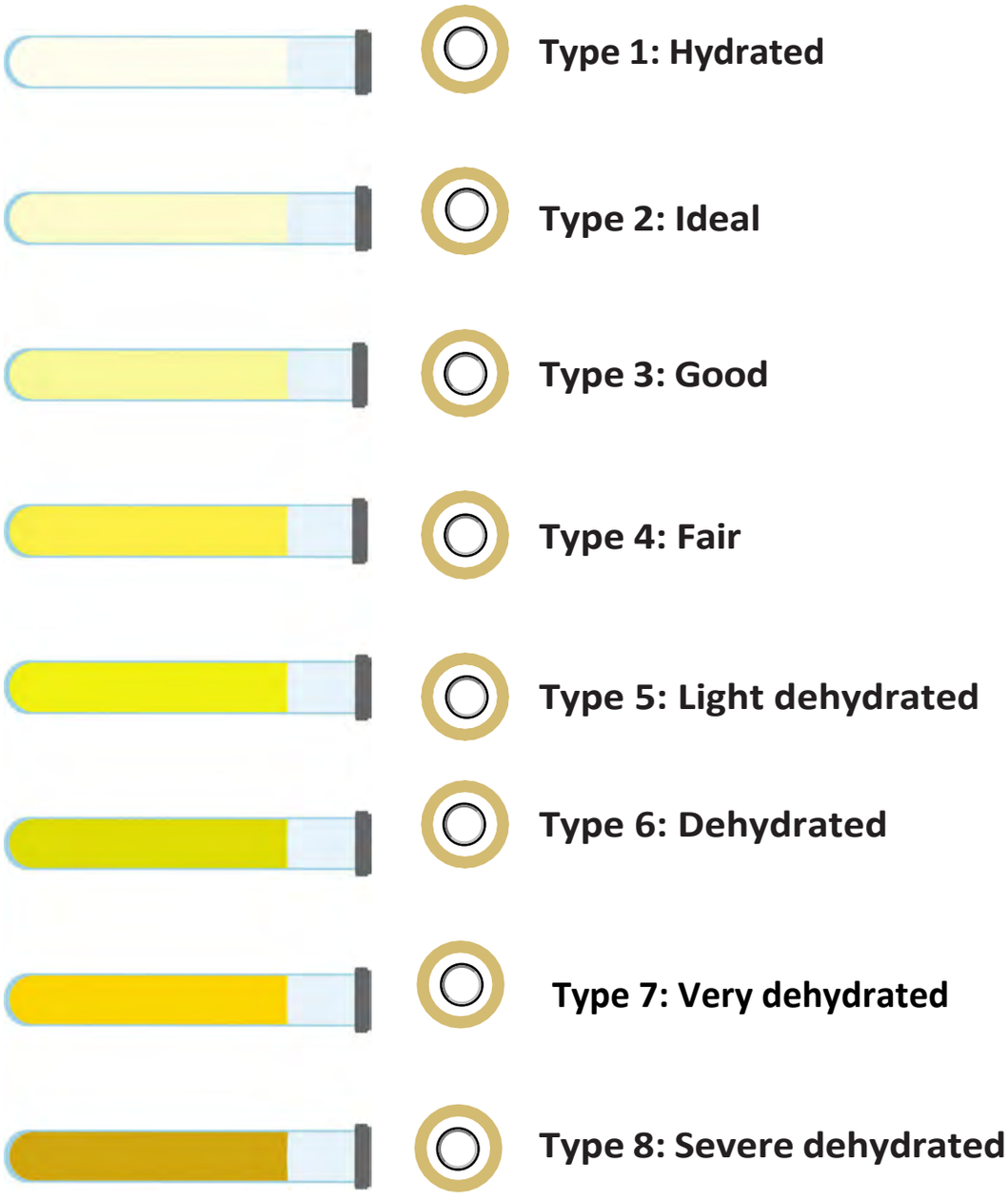
Yes ○ No ○

Continence

Wee

Do you have any other problems when you wee (things like going to the toilet a lot)?

What does your wee look like?



Continence

Is there any blood when you go to the toilet?

Yes ◯ No ◯

Do you see a continence nurse (this is someone who can look at causes, create treatment plans and empower people who can't always control when they go to the toilet)?

Yes ◯ No ◯

Do you have continence aids (things like pads or medicine)?

Yes ◯ No ◯

If yes, what?

My Family

Family

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

Yes ○ No ○

If yes, what?

Periods

Do you have periods?

Yes ○ No ○

Are your periods regular?

Yes ○ No ○

Are your periods painful?

Yes ○ No ○

Is the bleeding very heavy?

Yes ○ No ○

Periods

Have your periods changed?

Yes ◯ No ◯

Do you have any spotting or bleeding between periods?
For example, bleeding between periods?

Yes ◯ No ◯

Menopause

Have you had a discussion about the menopause with your nurse or doctor?

Yes ◯ No ◯

112. **Would you like any more information about the menopause?**

Yes ◯ No ◯

My Mental Health

Do you feel anxious or worried a lot of the time?

Yes ○ No ○

Do you feel sad for long periods of time and find it difficult to cheer yourself up?

Yes ○ No ○

Do you get angry and shout at people a lot?

Yes ○ No ○

Do you ever try to hurt yourself?

Yes ○ No ○

My Mental Health

Do you see a psychiatrist (this is someone who specialises in the prevention, diagnosis, and treatment of mental illness)?

Yes ○ No ○

Do you have support from the mental health team/Talking Therapies?

Yes ○ No ○

Do you have any other comments about your mental health?

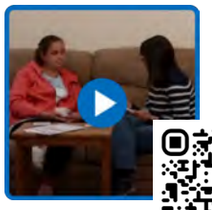
ReSPECT form

The ReSPECT form is a short plan about what should happen if you need health care or treatment in an emergency.

Do you have a ReSPECT form?

Yes ○ **No** ○

You can read an easy read guide about the ReSPECT form at:
www.resus.org.uk/respect/respect-resources



Watch a video about a GP introducing ReSPECT to Jenny and her Mother at:
https://youtu.be/vy_slyOuPAE

Watch a video about John talking about what is important to him about his end of life care at:
https://youtu.be/Yrq1zQotkaY

Hospital Passport

Have you got a Hospital Passport?
(Also known as, Health Passport, Communication Plan)

Yes ○ No ○

A form to provide healthcare professionals with information about you in an easy-to-understand way.

You can use this for hospital and GP appointments, with carers, dentists, opticians and many others.

If you want or need a Hospital passport for Norfolk and Waveney hospitals, you can download one by scanning the QR code or going to:
nwknowledgenow.nhs.uk/content-category/clinical-information/learning-disabilities-neurodevelopmental-disorders/information-for-patients

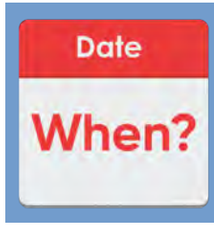
Any information you wish to share

What do you want to talk about at your health check?

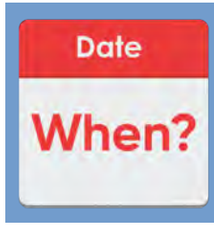
Any information you wish to share

What do you want to talk about at your health check?

Health Action Plan

 My health actions	 What are my next steps?	 Who will help me do this?	 Review date

Health Action Plan

 My health actions	 What are my next steps?	 Who will help me do this?	 Review date

What is in this booklet? (This is for GP reference)

Primary Care Accessible Resources

Resource 20: Pre-Health Check Questionnaire

Made in co-production

This booklet was originally co-produced by Ace Anglia, Self-Advocates, Suffolk Learning Disability Liaison Nurses, GP Doctors, Norfolk and Waveney ICB, Opening Doors Health Experts Group.

This booklet is **Resource 20** and forms part of a number of projects that help to explain things about primary care services.

The resources were funded by the NHS Suffolk and North East Essex Integrated Care System.

If you want to fill in the **pre-health check questionnaire** on a computer, please scan the QR code or download it from: **bit.ly/43jqRgn**

Open the pre-health check questionnaire in a **PDF Reader** and type in your answers.

You can ask your family or carer to help you.

When you have completed the pre-health check questionnaire **save it** and **send it** to the **email address** your **GP surgery** gave you.

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This booklet was last updated: 08/05/2025