Three Chequers Medical Practice incorporating:
Endless Street Surgery
Three Swans Surgery
Winterslow Surgery
Porton & Old Sarum Surgery

Three Chequers Medical Practice

Health Check for People with a Learning Disability

Please fill in these pages with the help of your carer (if you have one) before you come and visit the doctor. Please bring with you all your **medicines** whether prescribed by the doctor or not, your **health action plan** if you have one and a **urine sample** in a small bottle

Date of health check:	
Name:	
Date of Birth:	
Male / Female:	
Address:	
Main Carer:	
Key social care contact:	

Background		
Who looks after you? Tell us the names of all the people who look after you.		
	**Family carer ☐**	
	**Paid carer ☐**	
	**Healthcare worker ☐**	
	**Social care worker ☐**	
	**Are you a carer for anyone? (children, parents or partner)**	
	Yes ☐	**No ☐**
	**Are there any medical problems or illnesses that run in your family?**	
	Yes ☐	**No ☐**

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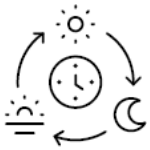
	**Do other people in your family have a learning disability?**	
	Yes ☐	**No ☐**
	**What are your likes or dislikes?**	
	**What are your capabilities?**	
	**How do you keep yourself safe?**	
	**Do you have a routine?**	
	**Has your carer noticed that sometimes you are not concentrating?** (e.g. seems to have absences)	
	Yes ☐	**No ☐**
	**How would you describe your personality?**	
	**Has your appetite changed recently?**	
	Yes ☐	**No ☐**

Partners: Dr Jeremy Howell · Dr Craig Kyte
Dr Michele Giorgi · Dr Helen Drayson · Dr Timothy Moody
Dr Peter Moody · Dr Hannah Clarke · Dr Daniel O'Sullivan
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	**What is your Religion?**
	How do you communicate? (tick as many as you like)
	Talking ☐
	Signing ☐
	Using a communication aid ☐
	Using gestures (nodding, pointing, raising eyebrows) ☐
	**What language do you speak and understand the most?**
	**Do you have difficulty in communicating?**
Yes ☐	**No ☐**
	If you do, what help do you need to communicate?

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Support		
	**Do you need support while performing personal care?**	
	Yes ☐	**No ☐**
	**Are you able to get in the bath by yourself or do you need help?**	
	Yes ☐	**No ☐**
	**Can you get dressed by yourself?**	
	Yes ☐	**No ☐**
	**Do you need support while feeding?**	
	Yes ☐	**No ☐**
	**How much fluid do you drink each day?**	
	_____	
	**Are you able to use the toilet by yourself?**	
	Yes ☐	**No ☐**
	**Please tell us about where you live. What kind of place is it?**	
	Family home ☐	
	Own home / flat ☐	
	A residential care home ☐	
	Supported living ☐	
	Other ☐	
	Are you able to move around easily?	

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	**Yes ☐**	**No ☐**	
	Do you use mobility aids? (a wheelchair, stick or frame?)		
	Yes ☐	**No ☐**	
	If so, what?		
	Has your mobility changed in the last year?		
	Got worse ☐	**Stayed the same ☐**	**Improved ☐**
	**Are you in a relationship?**		
	Yes ☐	**No ☐**	
	**Do you have a job?**		
	Yes ☐	**No ☐**	
	**What job do you do?**		

Lifestyle		
	Do you smoke?	
	Yes ☐	**No ☐**
	**How many cigarettes a day?**	
	_____	
	Would you like help to stop smoking?	
	Yes ☐	**No ☐**

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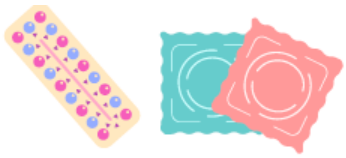
	**What exercise do you do?**	
	**Do you drink alcohol?**	
	Yes ☐	**No ☐**
	How many units* a week do you drink? (*A unit is half a pint of beer, a small glass of wine or a single shot of spirits)	
	_____	
	Do you want help to drink less alcohol?	
	Yes ☐	**No ☐**
	**Do you use any drugs like cannabis, ecstasy etc?**	
	Yes ☐	**No ☐**
	If Yes, do you want help to stop using these drugs?	
	Yes ☐	**No ☐**
	**Do you have sex?**	
	Yes ☐	**No ☐**
	Do you use contraceptives?	
	Yes ☐	**No ☐**

Mental Health			
	**How do you feel today?**		
	Happy ☐	**Not sure ☐**	**Sad ☐**

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Review		
	**What is your Ethnicity?**	
	**Do you have a Health Action Plan?**	
	Yes ☐	**No ☐**

Support		
	**Do you see an Occupational Therapist?**	
	Yes ☐	**No ☐**

Physical Health		
	**Do you have difficulty hearing?**	
	Yes ☐	**No ☐**
	**Do you have a hearing aid?**	
	Yes ☐	**No ☐**
	Do you wear it?	
	Yes ☐	**No ☐**
	Do you visit an audiologist?	
	Yes ☐	**No ☐**
	What is the date of your last appointment?	
	_____	
	Do you have any problems with your eyes and seeing things?	
	Yes ☐	**No ☐**

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	What was the date of your last optician's appointment?	
	_____	
	**Do you have any problems with your teeth or mouth?**	
	Yes ☐	**No ☐**
	If so, what?	
	**Do you visit the dentist regularly?**	
	Yes ☐	**No ☐**
	What is the date of your last appointment?	
	_____	
	**Do you get any pains in your chest?**	
	Yes ☐	**No ☐**
	When does this pain happen?	
	**Do you have any swelling of your ankles or feet?**	
	Yes ☐	**No ☐**
	**Do you feel you have an uneven heartbeat or your heart beating too fast?**	
	Yes ☐	**No ☐**

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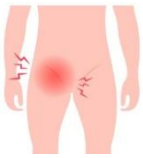
	**Do you have any pain in your abdomen?**	
	Yes ☐	**No ☐**
	**Have you got any swellings in your groin?** (just above the crease at the top of your legs?	
	Yes ☐	**No ☐**
	**Do you have any problems with your breathing?**	
	Yes ☐	**No ☐**
	Do you have a cough?	
	Yes ☐	**No ☐**
	Do you cough up anything?	
	Yes ☐	**No ☐**
	**Do you see a physiotherapist?**	
	Yes ☐	**No ☐**
	**Do you have any problem with your hair, skin or nails?**	
	Yes ☐	**No ☐**
	If so, what?	
	**Do you have problems sleeping?**	
	Yes ☐	**No ☐**

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	**Do you have any other health conditions?**

For Women		
	**Do you have periods?**	
	Yes ☐	**No ☐**
	Do you have any problems with your periods?	
	Yes ☐	**No ☐**
	Are your periods painful?	
	Yes ☐	**No ☐**
	Is your bleeding heavy?	
	Yes ☐	**No ☐**
	Is there any irregular bleeding? (for example, between periods)	
	Yes ☐	**No ☐**
	Do you have any vaginal discharge that is smelly or makes you sore?	
	Yes ☐	**No ☐**

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Mental Health		
	**Do you see a psychiatrist?**	
	Yes ☐	**No ☐**

Screening		
	**Do you have epilepsy?**	
	Yes ☐	**No ☐**
	If yes, what kind of epilepsy do you have?	
	In the last year have you started to shake or have movements that you cannot control?	
	Yes ☐	**No ☐**

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 ☐**
	When did you last do the test?	
	_____	

For Men:		
	**Has there been any pain or swelling in your testicles?**	
	Yes ☐	**No ☐**

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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 ☐**
	When was your last test?	
	_____	
	**If you are aged 25 to 64, have you had a cervical smear test?**	
	Yes ☐	**No ☐**
	When was your last test?	
	_____	

Allergies		
	**Do you have any allergies?**	
	Yes ☐	**No ☐**
	If so, do you know what your allergies are?	

Please bring this questionnaire with you to your appointment with the Healthcare Assistant.

Kind regards,

Administration Team
Three Chequers Medical Practice