# Annual Health - Checklist

Please fill in this form then return to GP Practice in envelope provided

Name:

Address:

Telephone:

Email:

## Reasonable Adjustments update

A reasonable adjustment is a small change your Doctor can make, to make any health appointment easier for you.

You may already have this but we want to update this with any changes you want so please think about this before we speak.

# Mobility

| | Do you have any of the following? | ✓ | ✗ | Comments |
|---|---|---|---|---|
| | Stiffness or difficulty moving? | | | |
| | Slowing of movements? | | | |
| | Pain when moving? | | | |
| | Falling or tripping? | | | |
| | Changes in posture / mobility? | | | |
| | Mobility equipment? | | | |
| | Swelling or redness in limbs / skin? | | | |

# Health Screening for Woman

| | **Do you have any of the following?** | ✓ | ✗ | **Comments** |
|---|---|---|---|---|
| | Do you check your breasts for any changes? | | | |
| Breasts | Any lumps in your breasts or armpits? | | | |
| | Any liquid from your nipple? | | | |
| | Any change to the skin on your breast? | | | |
| Nipple | Any changes to the shape of your nipple? | | | |
| | Do you have a change in colour to your breasts or nipples? | | | |
| | Do you check your breasts for any changes? | | | |

# Health Screening for Woman continued..

| | Do you have any of the following? | ✔ | ✘ | Comments |
|---|---|---|---|---|
| | Have you had any change in your period? E.g. heavy bleeding between periods, pain periods and vaginal discharge? | | | |
| | Do you feel tired? | | | |
| | Do you have mood swings? | | | |
| | Do you feel irritable? | | | |
| | Do you have hot flushes? | | | |

# Health Screening for Men

| | Do you have any of the following? | ✓ | ✗ | Comments |
|---|---|---|---|---|
| Testicles | Do you check your testicles / balls? | | | |
| | Have you felt / noticed any changes to your testicles / balls? | | | |

# Sexual Health

| | Do you have any of the following? | ✓ | ✗ | Comments |
|---|---|---|---|---|
| | Are you sexually active? | | | |
| | Do you use any contraception? | | | |

# Weight

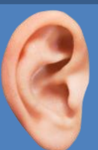
| | Do you have any of the following? | ✓ | ✗ | Comments |
|---|---|---|---|---|
| | Has your weight changed in the last 3 – 6 months? | | | |
| | What is your current weight, if known? | | | |

# Eyes

| | Do you have any of the following? | ✓ | ✗ | Comments |
|---|---|---|---|---|
| | When did you last have your eyes tested? | | | |
| | Do you have any eyesight problem or wear glasses? | | | |

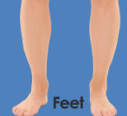
# Dentist

| | Do you have any of the following? | ✔ | ✘ | Comments |
|---|---|---|---|---|
| | Do you have a dentist? | | | |
| | When was your last visit? | | | |
| | Do your teeth hurt? | | | |
| | Do your gums bleed? | | | |
| | Do you have a swelling or a lump? | | | |
| | Do you have difficulty eating? | | | |



# Hearing

| | Do you have any of the following? | ✔ | ✘ | Comments |
|---|---|---|---|---|
| | Have you noticed any problems or changes to your hearing? | | | |
| | Do you think there is too much wax in your ears? | | | |

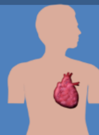



# Feet

| | Do you have any of the following? | ✔ | ✘ | Comments |
|---|---|---|---|---|
| | Have you been to a podiatrist or foot specialist? | | | |
| | When did you last go? | | | |
| | If not, who cuts your nails? | | | |
| | Do you have any pain in your feet? | | | |

# Breathing

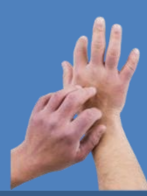
| | Do you have any of the following? | ✔ | ✘ | Comments |
|---|---|---|---|---|
| | Coughing that won't go away (more than 3 weeks)? | | | |
| | Coughing up blood? | | | |
| | Unusual coloured spit? | | | |
| | Wheeze or wheezing? | | | |
| | Hay fever, allergies, asthma or Chronic Obstructive Pulmonary Disease (COPD)? | | | |

#  Heart

| | Do you have any of the following? | ✔ | ✘ | Comments |
|---|---|---|---|---|
| | Difficult or laboured breathing during the day or night? | | | |
| | Chest pain when exercising? | | | |
| | Palpitations – feeling your heart beating without touching it? | | | |
| | Any swelling to the ankles, hands or body? | | | |

# Pain

| | Do you have any of the following? | ✔ | ✘ | Comments |
|---|---|---|---|---|
| | Do you have any pain? | | | |
| | Is this a new pain? | | | |
| | If you take pain relief medicine does this help? | | | |



# Skin

| | Do you have any of the following? | ✔ | ✘ | Comments |
|---|---|---|---|---|
| | Dry or itchy skin? | | | |
| | Warts? | | | |
| | Cold sores? | | | |
| | Sores or open wounds? | | | |
| | Do you have any changes to the colour of your skin on your body? | | | |

# Mental Health

| Do you have any of the following? | ✔ | ✘ | Comments |
|---|---|---|---|
| Do you have any worries about your memory or confusion? | | | |
| Feeling low, sad or unhappy? | | | |
| Feeling worried, frightened or anxious? | | | |
| Do you feel like crying? | | | |
| Have you injured yourself since your last review? | | | |
| Do you feel like you can't cope or look after yourself? | | | |
| Do you feel irritable, aggressive or violent? | | | |
| Have you thought about harming yourself or actually harmed yourself? | | | |
| Do you hear voices or see things? | | | |
| Have you spoken to someone about how you feel? | | | |

# Bowels / Poo

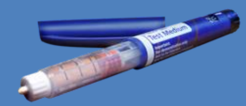
| | Do you have any of the following? | ✔ | ✘ | Comments |
|---|---|---|---|---|
| | Constipation – hard poo or can't go to the toilet? | | | |
| | Diarrhoea – watery poo and going too much? | | | |
| | Bleeding from your bottom? | | | |
| | Difficulty getting to the toilet on time? | | | |
| | Changes in bowel pattern? | | | |
| | Tiredness? | | | |
| | Are you aged 60 – 74? Have you received your bowel screening kit? | | | |
| | If you have, do you need any help to use the bowel screening kit? | | | |

# Eating & Drinking

| Eat | Do you have any of the following? | ✔ | ✘ | Comments |
| --- | --- | --- | --- | --- |
| | Does eating make you feel unwell? | | | |
| | Food allergies / intolerances? | | | |
| | Being Sick? | | | |
| | Do you have any changes to your appetite / hunger? | | | |
| | Do you eat things that are not food? | | | |
| | Difficulty swallowing? | | | |
| | Coughing when eating or drinking? | | | |
| | Do you use any supplements like multi-vitamins, fish oils, Complan? | | | |

# Epilepsy

| | Do you have any of the following? | ✔ | ✘ | Comments |
|---|---|---|---|---|
| | If you have epilepsy has your seizures changed? | | | |
| | Do you have an epilepsy Care Plan? | | | |
| | Do you take your epilepsy medication regularly and as prescribed? | | | |
| | Do you have any side effects i.e. feeling dizzy, sick, irritable or have blurred vision? | | | |



# Diabetes

| | **Do you have any of the following?** | ✔ | ✘ | **Comments** |
|---|---|---|---|---|
| | If you are diabetic do you test your blood sugar regularly? | | | |
| | Is your blood sugar in a safe range? | | | |
| | Do you have any problems with your eye sight? | | | |
| | Have you been for your diabetic eye screening? | | | |

# Medication Review

We need to talk to you about your medicines and look at whether your medications are still right for you?

If you have any problems taking your medication we can look at this when we speak.

# Care Passport

This is me

My Care Passport

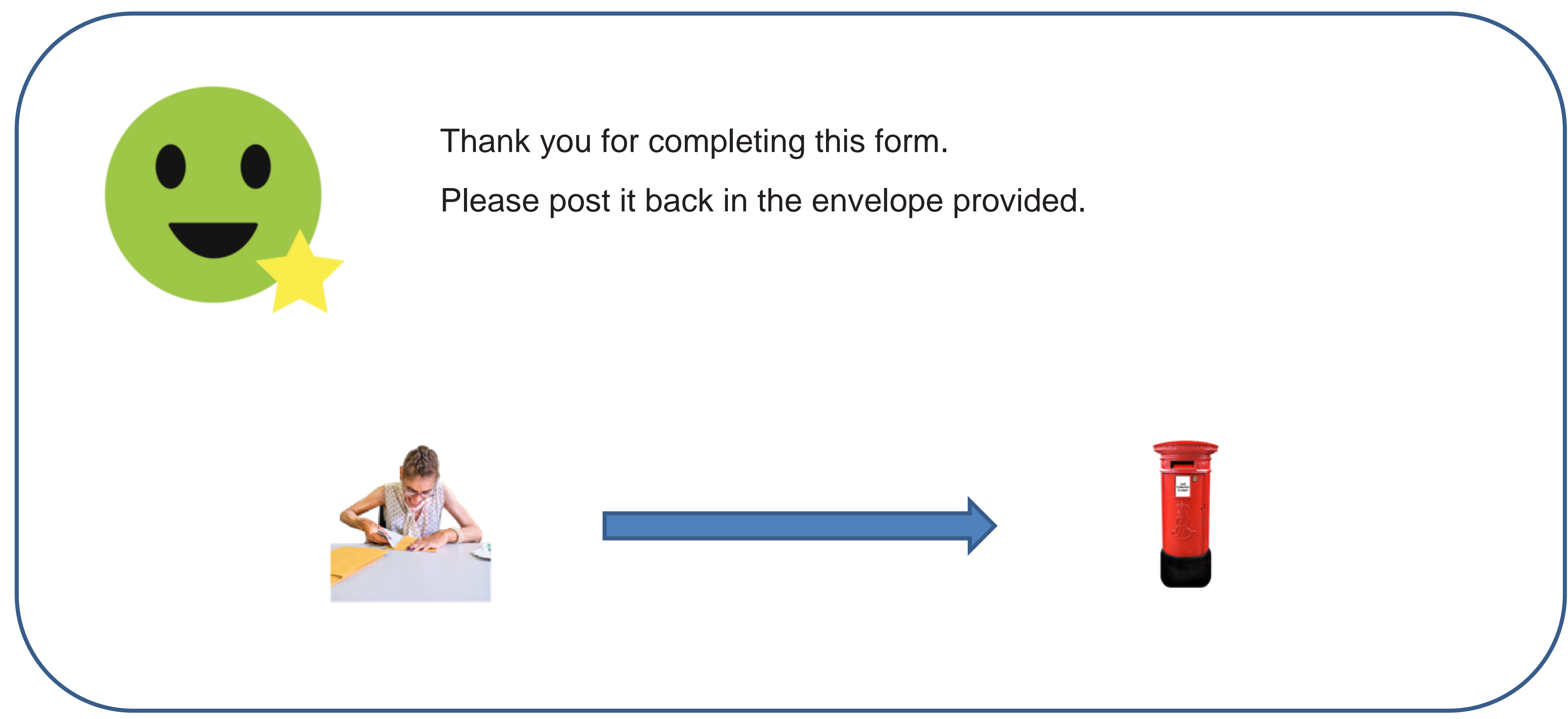
Do you have a Care Passport?

This can help all health professionals get to know you better.

# Questions

If you have any questions you can write them below or ask when we speak?

# Thank you


Thank you for completing this form.

Please post it back in the envelope provided.