

# Annual Health Check Checklist



This checklist is to help you think about your health and get ready for your Annual Health Check.



Please fill in this checklist **before** your Annual Health Check appointment.



You might want to ask someone who knows you well to help you.



Please bring this checklist with you when you come for your Annual Health Check.



There are some hard words in this checklist. They are written in **bold blue writing**. They are explained in **Hard words** on pages 30-33.

Your full name (first name and last name):	<hr/>
Your date of birth:	<hr/>
Your home address:	<hr/> <hr/> <hr/> <hr/> <hr/> <hr/>
Name of your main carer or support worker (if you have one):	<hr/>
Name and phone number of your social worker (if you have one):	<hr/> <hr/>
Date of your Annual Health Check:	<hr/>



Do you have a **Health Action Plan**?

Yes  No

If you do have a Health Action Plan, please fill it in and bring it with you to your Annual Health Check.



The information in this checklist and anything you say to the doctor or nurse will be kept **private**.

It is important that you tell the truth when you fill in this checklist. And when you answer the nurse or doctor's questions at your Annual Health Check.

This will help the nurse or doctor to understand your health needs. And make it easier to do your Annual Health Check properly.

## Communication



How do you normally communicate?

Talking

Signing

Pointing

Moving head or eyes

Using a communication aid



What language do you speak or understand the best?

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Tell us about any help you need to communicate or understand information:

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\_\_\_\_\_  
\_\_\_\_\_  
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Do you see a **speech and language therapist**?

Yes  No

### Daily life



Do you have a job?  
Or do you do any **voluntary work**?

Yes  No

If yes, tell us about your job or **voluntary work**:

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Tell us about where you live:

I live alone

I live with my partner or friend

I live with my parents/family

I live with a Shared Lives carer

I live in a residential school or college

I live in supported living

I live in a care home

I live in a residential home



Are you a carer for someone else? For example, do you have children that you look after? Or do you look after someone in your family who is ill or disabled?

Yes  No



If yes, tell us who you look after:

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## Allergies



Are you **allergic** to anything? For example medicines, food or bee stings.

Yes  No

If yes, tell us what you are allergic to:



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## Going to the doctor



Do you get scared or worried about anything when you go to the doctor, dentist or hospital?

Yes  No

If yes, tell us what you get scared or worried about:

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Tell us how we can help you feel less scared or worried when you come for your Annual Health Check:

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### Flu



Have you ever had a flu injection or flu nose spray?

Yes  No



If yes, when did you last have a flu injection or flu nose spray?

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### Pain



Do you have any pain?

Yes  No

If yes, tell us about any pain you have. For example:

- where the pain is
- what medicine you take for the pain
- what makes the pain better or worse.

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How would someone know that you were in pain?

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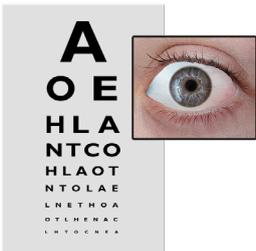
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## Eyes



Can you see well?

Yes  No

Do you wear glasses or contact lenses?

Yes  No



When did you last go to the **optician** for an eye test?

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Tell us about any problems with your eyes:

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### Ears



Can you hear well?

Yes  No



Do you wear a hearing aid?

Yes  No



Do you go to an **audiologist**?

Yes  No

If yes, when did you last go to the **audiologist**?

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Tell us about any problems with your ears:

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### Mouth



Tell us about any problems with your teeth, gums or mouth:

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When did you last go to the dentist?

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### Feet



Tell us about any problems with your feet:

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Do you see a **podiatrist** or **chiropodist** about your feet?

Yes  No

If yes, when did you last go to the **podiatrist** or **chiropodist**?

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## Moving around



Can you move around easily on your own?

Yes  No



Do you use anything to help you move around? For example a wheelchair, hoist, walking frame or walking stick?

Yes  No

If yes, tell us what you use to help you move around:

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Do you see a **physiotherapist** or **occupational therapist**?

Yes  No

If yes, tell us why you see the **physiotherapist** or **occupational therapist**:

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Tell us what exercise you do:

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### Alcohol, smoking and drugs



Do you drink alcohol?

Yes  No

If yes, tell us how much alcohol you drink **each week**:

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Do you smoke?

Yes  No

If yes, tell us how many cigarettes or cigars you smoke **each day**:

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Do you take any tablets or medicines that are **not** from your doctor? For example vitamins, painkillers or laxatives.

Yes  No

If yes, tell us what you take and why:

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Do you take any illegal drugs? For example cannabis or cocaine.

Yes  No

If yes, tell us what drugs you take:

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### Sex and contraception



Do you have sex?

Yes  No

If yes, tell us what **contraception** you use. For example **condoms**, the **pill** or nothing.

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### Sleeping, feelings and memory



Do you have any problems with sleeping?

Yes  No

If yes, tell us about any problems you have with sleeping:

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Have there been any big changes in your life recently? For example:

- Have you moved house?
- Have you changed school, college or job?
- Has someone you know become ill or died?

Yes  No

If yes, tell us about any big changes in your life and how you feel about these changes:

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Do you feel sad or upset **most** of the time?

Yes  No



Do you get angry a **lot**?

Yes  No



Do you feel worried or anxious a **lot**?

Yes  No



Do you ever hurt yourself? Or do you think about hurting yourself?

Yes  No



Have there been any changes to your memory? For example do you find it harder to remember things than you did before?

Yes  No



Do you see a **psychologist** or **psychiatrist**?

Yes  No

If yes, tell us why you see a **psychologist** or **psychiatrist**:

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### Eating and drinking



Do you have any problems with eating, drinking or swallowing?

Yes  No

If yes, tell us about any problems you have with eating, drinking or swallowing:

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Do you see a **dietician**?

Yes  No



Has your weight changed in the last year? For example have you put on a **lot** of weight or lost a **lot** of weight?

Yes  No

### Pooing and weeing



Do you have any problems going for a poo?

Yes  No

If yes, tell us about any problems you have with going for a poo. For example **constipation** or **diarrhoea**:

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Do you ever have blood in your poo?

Yes  No



Do you have any problems going for a wee?

Yes  No

If yes, tell us about any problems you have with going for a wee. For example needing to go a lot or finding it difficult to start weeing:

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Do you ever have blood in your wee?

Yes  No



Do you use **incontinence pads**?

Yes  No



Do you see a **continence nurse**?

Yes  No



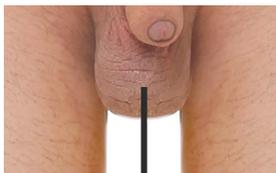
If you are between 60 and 69 years old, have you ever done a **bowel screening** test?

Yes  No

If yes, when did you last do a **bowel screening** test?

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### Men



**Testicles**

Do you check your testicles (balls) for lumps or any changes?

Yes  No



**Testicles**

Do you have any lumps or pain in your testicles (balls)?

Yes  No



If you are a man over 65 years old, have you been for an **abdominal aortic aneurysm (AAA) screening** test?

Yes  No

## Women



Do you check your breasts (boobs) for lumps or any changes?

Yes  No



Do you have any lumps or pain in your breasts (boobs)?

Yes  No



If you are a woman between 50 and 70 years old, have you ever been for a **breast screening** test?

Yes  No

If yes, when did you last go for a **breast screening** test?

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If you are a woman between 25 and 64 years old, have you ever been for a **cervical screening** test (smear test)?

Yes  No

If yes, when did you last have a **cervical screening** test (smear test)?

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Do you have periods?

Yes  No

If yes, tell us about any problems with your periods:



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Are you going through the **menopause**?  
Or do you think you might be starting the **menopause**?

Yes  No

If yes, tell us about any problems you are having with the **menopause**:



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### Skin, hair and nails



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

Yes  No

If yes, tell us about any problems with your skin, hair or nails:

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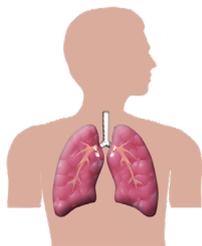
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### Breathing



Do you have **asthma**?

Yes  No



Do you have **emphysema** or **chronic obstructive pulmonary disorder (COPD)**?

Yes  No



Have you had a cough for more than 3 weeks?

Yes  No



Have you had a lot of chest infections?

Yes  No



Do you get out of breath easily?

Yes  No



Do you have any other problems with your breathing?

Yes  No

If yes, tell us about any other problems with your breathing:

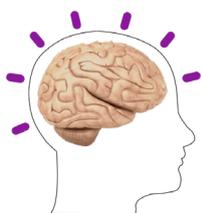
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### Brain



Do you have **epilepsy**?

Yes  No

If yes, tell us what type of **epilepsy** you have:



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How many **seizures** (fits) do you have **in a month**?

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What medicines or tablets do you take for your **epilepsy**?

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Do you see a special doctor or consultant about your **epilepsy**?

Yes  No

If yes, tell us when you last saw your **epilepsy** doctor or consultant:

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Tell us about anything that causes or triggers your **seizures** (fits). For example lights, temperature, being tired or stressed:

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Have you ever had a **stroke**?

Yes  No

If yes, tell us when you had a **stroke**:

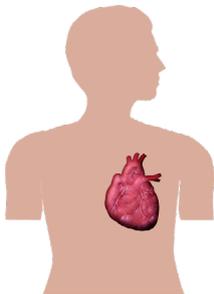
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Do you sometimes faint or have blackouts?

Yes  No

## Heart

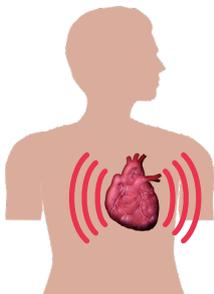


Have you ever had a heart attack?

Yes  No

If yes, tell us when you had a heart attack:

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Do you sometimes feel like your heart is beating too fast, even when you have not done any exercise?

Yes  No



Do you get any pain in your chest?

Yes  No

If yes, when do you get pain in your chest?  
For example when you do exercise or when you lie down:

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Do you get swelling in your feet, ankles or anywhere else on your body?

Yes  No

## Diabetes



Do you have **diabetes**?

Yes  No



## Going to your Annual Health Check



Please remember to bring with you to your Annual Health Check:

- This checklist
- Your Health Action Plan (if you have it)
- All your medication
- Some of your wee in the bottle you were sent
- Anything else that your doctor or nurse has asked you to bring.



You can take someone with you to your Annual Health Check if you want.

This can be a friend, **advocate**, support worker or someone from your family.

You can also talk to the nurse or doctor in private if you want to.



If you are ill or worried about your health in between your Annual Health Check, make sure you book an appointment with your doctor.

## Hard words

### Abdominal aortic aneurysm (AAA) screening

This is a test for men over 65 years old. The test checks the biggest artery in the body called the aorta. An artery takes blood around the body.

### Advocate

An advocate helps you to speak up for yourself. Or they speak up for you if you cannot speak for yourself.

### Allergic

If you are allergic to something it can make you very ill. It might make you sick or give you a rash. It could even kill you.

### Asthma

If you have asthma, you might get out of breath sometimes. You might need an inhaler to help your breathe.

### Audiologist

An audiologist checks your hearing.

### Breast screening

This is a test for women between 50 and 70 years old. The test checks a woman's breasts for signs of breast cancer.

### Bowel screening

This is a test for anyone between 60 and 69 years old. The test checks your poo for signs of bowel cancer.

## Cervical screening

This is a test for women between 25 and 64 years old. It is often called a smear test. The test checks inside a woman's body for signs of cervical cancer. Cervical means at the opening of the womb inside a woman's body.

## Condoms

These are a type of contraception. The condom goes on the man's penis before sex. It stays on while you have sex. It can stop you from catching some diseases when you have sex. It can also stop women from getting pregnant when they have sex.

## Constipation

This is when it is very difficult for you to go for a poo.

## Continence nurse

A continence nurse helps when you have problems controlling when you go for a wee or a poo.

## Contraception

Contraception is something you use to stop a woman getting pregnant when having sex. For example a man wearing a condom or a woman taking the pill.

## Diabetes

This is an illness that means the sugar in your blood gets too high. If you have diabetes you have to be very careful about what you eat and drink.

## Diarrhoea

If you have diarrhoea your poo is usually very runny or watery.

### **Dietician**

A dietician helps you to eat and drink the right things to stay healthy.

### **Emphysema or chronic obstructive pulmonary disorder (COPD)**

These are illnesses that cause damage to your lungs. This makes it difficult to breathe.

### **Epilepsy**

Epilepsy is a problem with the brain. It causes you to have seizures or fits.

### **Incontinence pads**

These are for when you cannot control when you go for a wee or a poo. You wear them in your pants.

### **Menopause**

The menopause is when a woman's body changes as she gets older. It means her periods stop. When a woman goes through the menopause she might not feel very well. For example she might feel very hot or find it difficult to sleep.

### **Occupational therapist**

An occupational therapist helps you to do things in your daily life. They can help you stay independent.

### **Optician**

An optician checks your eyes. They can check that your eyes are healthy. They can also check how well you can see.

### **Physiotherapist**

A physiotherapist helps you to move your body.

### Pill

The pill is a type of contraception. Women take the pill to stop them getting pregnant when they have sex.

### Podiatrists or chiropodists

Podiatrists and chiropodists look after people's feet and toenails.

### Psychologist or psychiatrist

A psychologist or psychiatrist can help with your thoughts or feelings.

### Seizure

There are different types of seizure or fit. You might go stiff or your body might shake. You might fall down on the floor. People with epilepsy usually have seizures or fits.

### Speech and language therapist

A speech and language therapist helps people with talking, swallowing and communicating.

### Stroke

A stroke is when blood cannot get to part of the brain properly. It can cause problems in different parts of the body. For example you might not be able to walk or talk properly.

### Voluntary work

This means work that you do not get paid for. It is usually for charities to help people, animals or the community.



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