My Annual Health Check Passport

This Annual Health Check Passport gives the Doctor or Nurse important information about you. Please take it with you when you go to see the Doctor or Nurse for your Annual Health Check.

My name is:

Do you have support from the CTLD? Yes  ❑  No  ❑

My Care Manager is:

Social Worker:

Nurse:

Health Care Support Worker:

My Health Facilitator or key worker is:
My Next of kin is:

Another important person:

Another important person:

**Communication**

How I make my needs known:

Language/s my carer speaks: .................................................................

How would you describe yourself? (ethnicity)
Date of your health check:  

Who was at your health check?

☐ Tick the box if you have a Health Action Plan sheet with a list of agreed health goals. Please bring it with you.

Remember to bring a list of your medication with you.

Remember to bring a sample of wee with you.

What the Doctor/Nurse said at your health check:

I have the following allergies:
Do you drink alcohol?  Yes ☐  No ☐
If yes, how much per week?

Have you ever smoked?  Yes ☐  No ☐
If yes, how many per day?

Is there anything else you would like to tell us?

What the Doctor/Nurse said at your health check:
Do you have any illnesses or conditions that stop you doing the things you like to do?

Asthma □  Diabetes □  Underactive thyroid □

Epilepsy □  Other □  Please tell us what it is?

Does any member of your family have any illnesses or conditions that we should know about? Please tell us what they are:

Please tick the box if your family history is not known □

What the Doctor/Nurse said at your health check:

Completed by carer:

Height:  Weight:
The nurse will now take some important measurements.

Blood pressure: 

Pulse: 

The nurse might take some blood.

Are you worried about having a blood test

*If yes refer to CTLD for support*

The nurse will check if you have had a flu jab.

The nurse will check if you need a pneumococcal jab

What the Doctor/Nurse said at your health check:
Do you often choke on your food?
Yes ☐  No ☐

Do you follow a special diet? Yes ☐  No ☐

If yes, Please tell us what it is:

Have you seen a dietician?
Yes ☐  No ☐  If yes, please tell us:
When?
Where?

Have you seen a Speech and Language therapist?
Yes ☐  No ☐  If yes, please tell us:
When?
Where?
Is there anything else you want to tell us about your diet?

What the Doctor/Nurse said at your health check:
Do you have difficulties having a wee? Yes ☐ No ☐

If yes, tell us more.

Do you find it difficult getting to the toilet on time? Yes ☐ No ☐

If yes, how often?

Do you have any difficulties having a poo? Yes ☐ No ☐

If yes, tell us more.

Do you have runny poo? Yes ☐ No ☐

If yes, how often?
Do you use any continence equipment?
Yes ☐ No ☐

Do you use any continence products?
Yes ☐ No ☐

Is there anything else you want to tell us?

What the Doctor/Nurse said at your health check?
Are you physically active?
Yes ☐ No ☐

Do you use a wheelchair or other mobility equipment?
Yes ☐ No ☐

Is there anything else you would like to tell us?

What activities do you take part in?

What the Doctor/Nurse said at your health check:
When I am well:

When I am unwell:

When I am in pain:
Are you registered with a Dentist?

Yes ☐ No ☐ If yes, where is it?

When was the last time you went for a check-up?

Are there any dental issues you want to tell us about?

What the Doctor/Nurse said at your health check:
Do you wear glasses?  
Yes ☐ No ☐

Do your eyes hurt?  
Yes ☐ No ☐

Have you had an eye test?  
Yes ☐ No ☐  If yes, please tell us:
When?

Where?

Tell us if there have been any changes to your eyes that you are worried about.

What the Doctor/Nurse said at your health check:
Have you had a hearing test?
Yes ☐ No ☐  If yes, please tell us:
When?  
Where?  

Has anyone thought that you may have a hearing problem?
Yes ☐ No ☐

Tell us if there have been any changes to your ears that you are worried about.

What the Doctor/Nurse said at your health check:
Have you had any treatment to your feet?
Yes ☐  No ☐  If yes, please tell us:
When? ____________________________
Where? ___________________________

Do your feet: Itch ☐  Hurt ☐  Or itch and hurt ☐

Can you cut your own toe nails?
Yes ☐  No ☐

Is there anything else you want to tell us about your feet?

What the Doctor/Nurse said at your health check:
Do you have epilepsy?  
Yes ☐  No ☐  
What are your seizures called?  

How many seizures do you have in a month?  

Please bring your seizure record with you.

Who is your epilepsy Doctor?  

When?  

Where?  

Is there anything else you want to tell us?  

What the Doctor/Nurse said at your health check?
How are you feeling?

Do you easily get upset?
Yes ☐ No ☐ If yes, tell us why:

Are you worried about anything?
Yes ☐ No ☐ If yes, tell us what:

Do you sometimes feel like hurting yourself or others?
Yes ☐ No ☐ If yes, do you know why?

Are you on Care Programme Approach? Yes ☐ No ☐
Who is your Care Programme Approach Co-ordinator?

Do you see a Psychiatrist?
Yes ☐ No ☐ If yes, who is it?

When and where were you last seen?
When?
Where?

Is there anything else you want to tell us?

What the Doctor/Nurse said at your health check:
Do you have specific condition associated with a learning disability?

For example Down’s Syndrome, Fragile X Syndrome, Prader Willi Syndrome

What the Doctor/Nurse said at your health check:
The nurse will ask you questions about your body. This is to make sure you are offered the right check-ups to help you stay healthy.

**TOP TIP!**
Consider MENTAL CAPACITY, CONSENT AND BEST INTEREST.

Have you ever had a testicular examination?

Yes □ No □ If yes, please tell us:

When?

Where?

Do you know how to check your testicles? Yes □ No □

Have you ever had a bowel screen?

Yes □ No □ If yes, please tell us:

When?

Where?

Are you sexually active? Yes □ No □

Do you use any contraception?

Yes □ No □ If yes, tell us what you use.
Is there anything else you would like to tell us?

What the Doctor/Nurse said at your health check:
The Nurse will ask you questions about your body. This is to make sure you are offered the right check-ups to help you stay healthy.

**TOP TIP!**
Consider MENTAL CAPACITY, CONSENT AND BEST INTEREST.

Have you ever had a smear test?

Yes ☐ No ☐ If yes, please tell us:

When?

Where?

Do you know how to examine your breasts? Yes ☐ No ☐

Have you ever had a breast screen?

Yes ☐ No ☐ If yes, please tell us:

When?

Where?

Have you ever had a bowel screen?

Yes ☐ No ☐ If yes, please tell us:

When?

Where?
Are you sexually active?
Yes ☐ No ☐

Do you use any contraception?
Yes ☐ No ☐ If yes, tell us what you use.

Do you have periods?
Yes ☐ No ☐

Do you have any problems managing your periods?
Yes ☐ No ☐

Do you think you are in the menopause?
Yes ☐ No ☐

What symptoms do you have?
Is there anything else you would like to tell us?

What the Doctor/Nurse said at your health check:
My Health Action Plan

Date:

My name is:

Practice Nurse:

Doctor:

Any medication changes (please tick ✔️) Yes ❑ No ❑

If yes please list:
<table>
<thead>
<tr>
<th>My Health Action Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>My Health Need</td>
</tr>
<tr>
<td>1</td>
</tr>
<tr>
<td>2</td>
</tr>
<tr>
<td>3</td>
</tr>
<tr>
<td>4</td>
</tr>
<tr>
<td>5</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>What needs to be done?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Who will help me?</td>
</tr>
<tr>
<td>When will this need to be reviewed?</td>
</tr>
<tr>
<td>My Health Action Plan</td>
</tr>
<tr>
<td>----------------------</td>
</tr>
<tr>
<td>My Health Need</td>
</tr>
<tr>
<td>6</td>
</tr>
<tr>
<td>7</td>
</tr>
<tr>
<td>8</td>
</tr>
<tr>
<td>9</td>
</tr>
<tr>
<td>10</td>
</tr>
<tr>
<td>What needs to be done?</td>
</tr>
<tr>
<td>Who will help me?</td>
</tr>
<tr>
<td>When will this need to be reviewed?</td>
</tr>
</tbody>
</table>

---

My Annual Health Check Passport