THE SCOTTISH LEARNING DISABILITIES HEALTH CHECK PROGRAMME

Please try to answers these questions with a relative or person who supports you. Bring this with you when you see the nurse for your health check. Don't worry if you don't know the answers to some questions.

1. My name is …….

2. Should the nurse do something to help you understand better? What should she do?....…….....
   .....

3. Do you have any current health problems or concerns?.....
   ……...…
   ……...
   ……...
   ……...

4. What drugs are you currently taking, and what dose and how often?

Drug name	Drug dose	When do you take it?

5. Do you have epilepsy? …….

6. If you have epilepsy, how often do you have seizures?.....
   ……...

7. Do you have any of these symptoms or problems?
   a. Coughing.……
   b. Breathing problems.……
   c. Wheezing……
   d. Phlegm or snot……
   e. Chest or leg pain when you exercise……..
   f. Swollen ankles……
   g. Skin, scalp or foot problem.……
   h. Problems passing urine, or passing water too often, or blood in your water, or pain passing water……
   i. Incontinence – long term or recent?....……...
   j. Bowel problem or blood in your motions/poo……

   ……...
   ……...
   ……...
   ……...
   ……...

8. Have you ever had a problem with choking?.....
   ……...

9. Do you have a problem with constipation?.....
   ……...

10. Do you have a problem (suggesting reflux or a gullet problem) with

    a. Regurgitation…….….
    b. Vomiting……
    c. Heartburn……....
    d. Indigestion…….….
    e. Getting off to sleep, or sleeping through the night……..…
    f. Coughing bouts after eating……...

……...

……...

……...

11. Do you have any sight problems?.....

12. When did you last have an eye sight test?.....

13. Do you have any hearing problems?.....

14. When did you last have your hearing tested or a hearing aid review?.....

……..

15. Do you have any problems with

    a. Feeling anxious or nervous or panicky……..
    b. Always having to double check things, or do things in a particular order……
    c. Feeling down, depressed, low, unhappy or miserable ……
    d. Not wanting to mix with other people……
    e. Not communicating as much as usual……
    f. Being tearful, or crying……..
    g. Increased irritability……

h. Not looking after yourself as well as usual……
i. Having much more energy than usual, or loss of energy……..
j. Getting muddled up about things, or confused, or forgetful……..
k. Not sleeping as well as usual, or sleeping too much…….
l. Not eating as much as usual, or having gone off your food……..
m. Loss of concentration…….
n. Problem behaviours……..…….
o. Needing more reassurance than usual……
p. Being more suspicious than usual…….
q. Hearing voices that other people can't hear……..

……...

……...

……...

……...

……...

16. Do you have a lot of accidents or falls?.....

……...

17. If you use any equipment or aids, are they useful, and does anyone who supports you need any training in their use?.....

……

18. Do you have any mobility problems?.....

……...

19. If you use walking aids or a wheelchair, when did you last have a review?

.....

20. Do you want a review of your support package, such as any respite care you use, day care, benefits, or any other support?.....
……

21. When did you last see a dentist?.....

22. Do you smoke?.....

23. How much exercise do you get?.....
……..

24. Do you want any advice on what you eat or your weight?.....
……...

25. How much alcohol do you drink?.....

26. What is the name and address of your welfare guardian?.....
……..
……..
Telephone……..

27. What is the name and address of your next of kin?.....
……..
……..
Telephone……..

28. Are there any reasons why we should not contact your next of kin? Yes [ ]
No [ ]

Who has filled in this form?.....

If you have filled the form in for a person you care for or support, what is your relationship?.....

If you are a carer, how well do you know the person?.....

What is today's date……...