Pre Health Check Questionnaire

My Name _____

We would like to share information about you with other health care professionals,

Is this OK?  ☐ or  ☐

Are you getting help to complete this form?

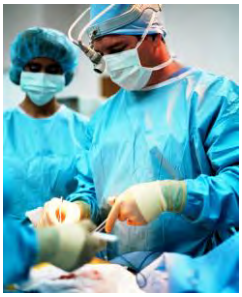
 ☐ or  ☐

If you are helped to complete this form who is helping you?

Name: _____

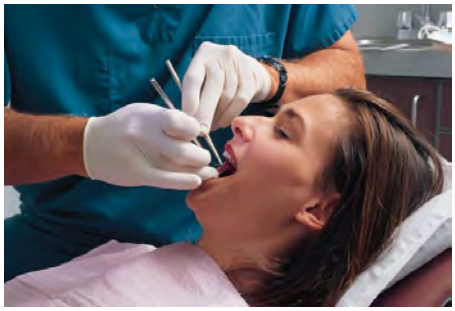
Diagnosis (if known)

Any known health problems,
(E.g. epilepsy or diabetes)



Have you ever had an operation?

Is there any history of illness in your family?



Do you go to the dentist?

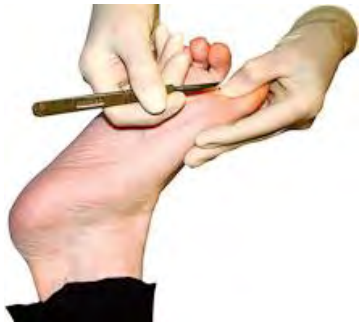
 ☐ or  ☐

Last appointment: _____

Do you go to the optician?

 ☐ or  ☐

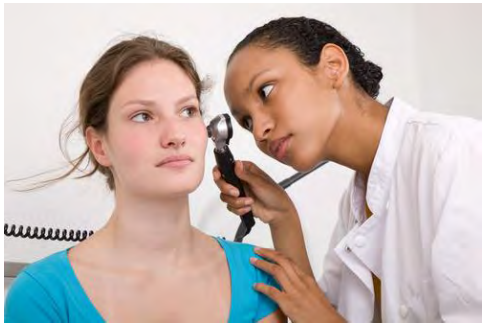
Last appointment: _____



Do you go to the chiropodist?

 ☐ or  ☐

Last appointment: _____



Have you had your hearing checked?

 ☐ or  ☐

Last appointment: _____

Do you have Epilepsy?

 ☐ or  ☐

If yes, how many seizures do you have a month?

_____

Who is your Epilepsy Doctor or Nurse?

_____

_____

Anything else you want to tell us? (e.g. do you have any regular aches or pain)?

_____

_____

_____

_____

_____

Do you have any problems going to the toilet?

 ☐ or  ☐

If yes;

Do you have problems going for a wee (passing urine)?

 ☐ or  ☐

Do you have problems going for a poo (passing a stool)?

 ☐ or  ☐

Your Feelings

How are you feeling?

_____

_____

_____

_____

_____

Do you have any worries?

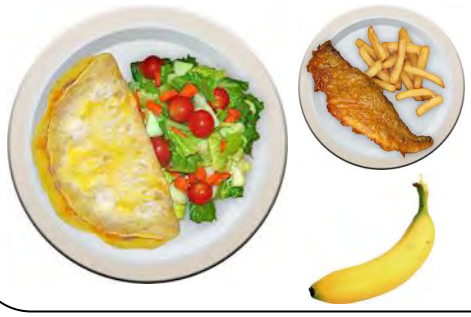
_____

_____

Have you spoken to anyone for help about this?

_____

_____



Diet

Do you have problems with chewing or swallowing?

 ☐ or  ☐

_____

_____

Do you have special dietary needs?

 ☐ or  ☐

_____

_____

Have you seen a Speech & Language Therapist / Dietician?

 ☐ or  ☐

_____

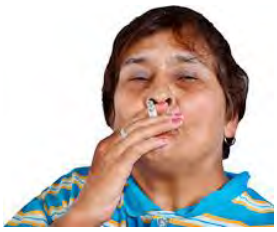
_____

Can you choose what you eat?

 ☐ or  ☐

What food do you like to eat?

My Lifestyle



Do you smoke? _____

Do you drink alcohol? _____

Do you want any information about this?

 ☐ or  ☐

_____

_____

_____

Do you exercise?

 ☐ or  ☐

Do you have opportunities to exercise?

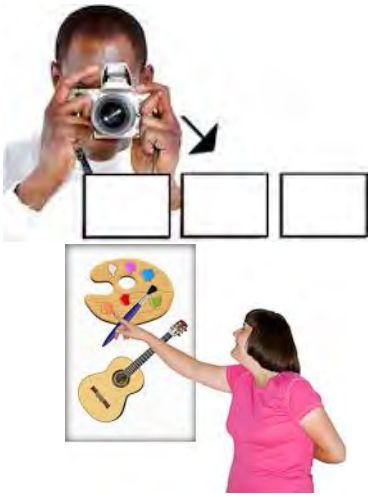
 ☐ or  ☐

_____

_____

_____

_____



Do you have any hobbies?

 or 

Can you choose what you want to do?

 or 

Do you have a job?

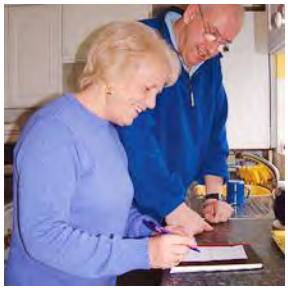
 or 

Are you training for a job?

 or 

Do you live in your own house?

 ☐ or  ☐



Are you getting support to do the things you want to?

 ☐ or  ☐

Things you need to bring with you to your health check

Urine sample

Your Medication

_____

_____

_____

_____

_____