



Get Checked Out Checklist

Please fill this book in and bring it back to the GP surgery



Date:



Name:

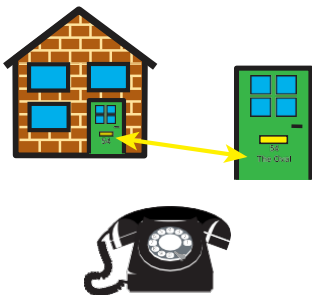
I prefer:



Date of birth:



Who is important to you?
.....
.....
.....
.....



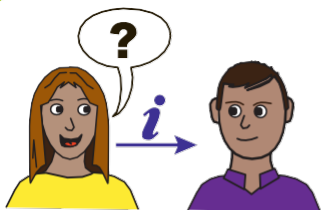
Address:

.....
.....
.....
..... Telephone



Email:

Consent for Summary Care Record and additional information



Your Doctor will have your basic summary care record. It has information about your health, the medications which you take and any medications which might make you ill (allergic reaction)



A doctor or nurse who doesn't know you very well, might ask to look at your Summary Care Record, this gives them the right information to care for you.



Only people like a doctor or nurse who are treating you can see your summary care record.

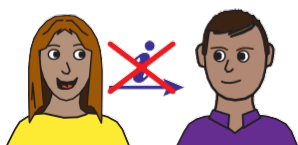
The Doctor can add extra information to your record with things like a history of your health problems, operations, or an illness you've had. It can include information about who supports you and what help or type of information you might need at appointments.



The extra information can help doctors and nurses, no matter where you are treated, look after you and help keep you well.



If you would like extra information adding to your summary care record about your health and what support you need let your Doctor know.



If you don't want your information on your Summary Care record you can ask your doctor to remove it.



Do you consent to sharing information

1. Consent for electronic record sharing?
2. Consent for summary care record with additional information?
3. Consent to share data with another professional? (specified third party)

yes

no

The Equality Act (2010) - Reasonable Adjustments Alert



A reasonable adjustment is a small change your Doctor can make, to make your Annual Health Check easier for you. Below are examples of reasonable adjustments. Below are examples of reasonable adjustments. You can get help to write down what you need in the blank section at the end of this document. You can ask for these reasonable adjustments to be available for you at your annual health check.

Reasonable Adjustment	How you can help me	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Comments
	<p>I need easy read documents.</p> <p>I need information in Braille</p> <p>I need information in large print.</p> <p>I need information in another language – if so what language?</p>	<p><input type="checkbox"/></p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p>	<p><input type="checkbox"/></p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p> <p><input type="checkbox"/></p>	<p></p> <p></p> <p></p> <p></p>
	<p>I use a wheelchair and will need a hoist if I need a physical examination. I may need a home visit in this instance.</p>	<p><input type="checkbox"/></p>	<p><input type="checkbox"/></p>	<p></p>
	<p>I find it difficult to wait in the doctors for my appointment, as it may make me anxious. I may need to wait outside until you are ready to see me.</p>	<p><input type="checkbox"/></p>	<p><input type="checkbox"/></p>	<p></p>
	<p>I get very nervous at appointments and need my carer to help me understand what is happening.</p>	<p><input type="checkbox"/></p>	<p><input type="checkbox"/></p>	<p></p>

Reasonable Adjustment

How you can help me

Yes No

Comments



I may need to visit the surgery before my appointment to feel comfortable in the environment.



I need a longer appointment.

I need time to process information and answer questions.

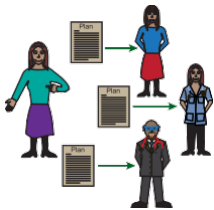


Bright lights or loud noises may affect me.

My carer will support you to understand my needs.



Please also alert my carer of any appointments.



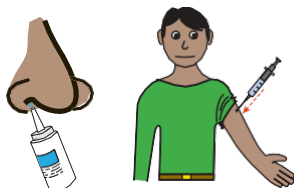
Other reasonable adjustments?



Flu

Yes No

Comments



Have you had your nasal spray or flu vaccine injection?



Mobility

Yes ✓	No ✗
<input type="checkbox"/>	<input type="checkbox"/>

Comments

Stiffness or difficulty moving.

<input type="checkbox"/>	<input type="checkbox"/>
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Slowing of movements.

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

Pain when moving.

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

Falling or tripping.

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

Changes in posture/mobility.

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

Mobility equipment used.

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

Swelling or redness in limbs/skin.

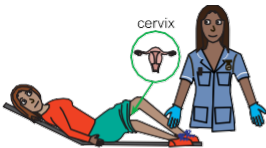
<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------



Health Screening - Women

Yes ✓	No ✗
<input type="checkbox"/>	<input type="checkbox"/>

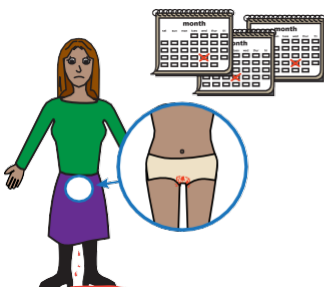
Comments



Have you had a smear test?

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

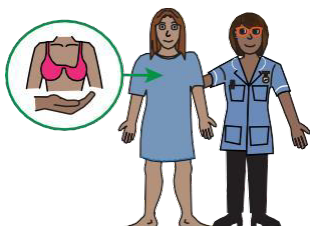
https://assets.publishing.service.gov.uk/media/667abe64c7f64e234208ffa2/CSP05_easy_guide_to_cervical_screening_June_2024_PDF.pdf



Change in periods e.g. heavy bleeding in between periods, painful periods, Vaginal discharge

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

If there is a problem then please bring your menstrual chart with you if you have one.



If you are over 50 have you had a mammogram?

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

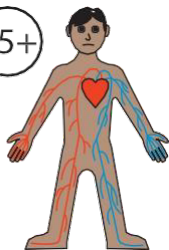


Health Screening - Men

Yes ✓	No ✗
<input type="checkbox"/>	<input type="checkbox"/>

Comments

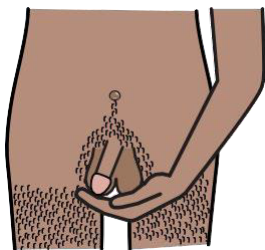
65+



Have you had your Abdominal Aortic Aneurysm or AAA Screening?

<input type="checkbox"/>	<input type="checkbox"/>
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https://assets.publishing.service.gov.uk/media/5f451a98e90e074c4ea3c608/AAA_screening_easy_guide_August_2020.pdf

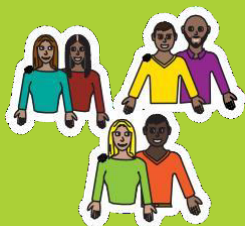


Do you check your own testicles / balls

<input type="checkbox"/>	<input type="checkbox"/>
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Have you felt/noticed any changes to your testicles/balls?

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------



Sexual Health

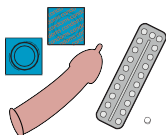
Yes ✓	No ✗
<input type="checkbox"/>	<input type="checkbox"/>

Comments



Are you sexually active?

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------



Do you use any contraception?

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------



Weight

Yes ✓	No ✗
<input type="checkbox"/>	<input type="checkbox"/>

Comments

Has your weight changed in the last 3 – 6 months?

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

Do you need specialist equipment to weigh you?

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------



Dentist

Yes ✓	No ✗
<input type="checkbox"/>	<input type="checkbox"/>

Comments

Do you have a dentist?
When was your last visit?

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

Do your teeth hurt?

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

Do your gums bleed?

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

Do you have a swelling or a lump?

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

Do you have difficulty eating?

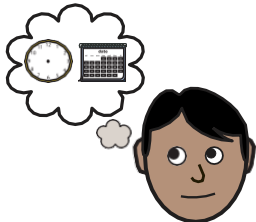
<input type="checkbox"/>	<input type="checkbox"/>
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Eyes

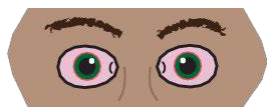
Yes ✓	No ✗
<input type="checkbox"/>	<input type="checkbox"/>

Comments



When did you last have your eyes tested

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------



Do you have any eyesight problems or wear glasses

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------



Hearing

Yes ✓	No ✗
<input type="checkbox"/>	<input type="checkbox"/>

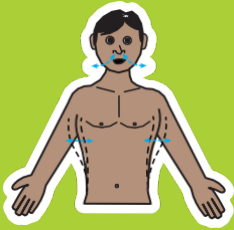
Comments

Have you noticed any problems or changes to your hearing?

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

Have you visited a hearing clinic (audiologist)?

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------



Breathing

Yes ✓	No ✗
<input type="checkbox"/>	<input type="checkbox"/>

Comments

Coughing that won't go away (more than 3 weeks)

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

Chest infection

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

Coughing up blood

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

Unusual coloured spit

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

Wheeze

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

Hay fever, allergies, asthma or chronic obstructive pulmonary disease

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

Breathlessness

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

Do you smoke?

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------



Eating and Drinking

Yes ✓	No ✗
<input type="checkbox"/>	<input type="checkbox"/>

Comments

Does eating make you feel unwell?

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

Food allergies/intolerances

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

Being sick

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

Do you have any changes to your appetite/hunger?

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

Do you eat things that are not food?

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

Difficulty swallowing

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

Coughing when eating or drinking

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

Do you use any supplements like multi vitamins, fish oils, Complan etc.?

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------



Bowels

Yes ✓	No ✗
<input type="checkbox"/>	<input type="checkbox"/>

Comments

Constipation – hard poo or can't go to the toilet

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

Diarrhoea– watery poo and going too much

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

Bleeding from your bottom

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

Difficulty getting to the toilet on time

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

Changes in bowel pattern

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

Fatigue

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

Are you aged 60-74? Have you received your bowel screening kit?

<input type="checkbox"/>	<input type="checkbox"/>
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https://assets.publishing.service.gov.uk/media/646dfec324315700136f4184/2023.04.17_nhs-bowel-screening_FIT_EasyRead-Leaflet-WebAcc.pdf



Urine

Yes ✓	No ✗
<input type="checkbox"/>	<input type="checkbox"/>

Comments

Pain when you wee?

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

Urine infection

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

Wee more often?

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

Do you find it difficult to start weeing?

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

Does your wee start and stop when you are weeing?

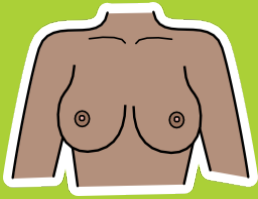
<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

Blood in your wee

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

Difficulty in getting to the toilet in time?

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------



Breasts

Yes ✓	No ✗
<input type="checkbox"/>	<input type="checkbox"/>

Comments

Any lumps in breasts or armpits?

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

Any liquid from your nipple?

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

Any changes in the shape of your breasts?

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

Any changes to the skin on your breasts?

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

Any changes to shape of your nipples?

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

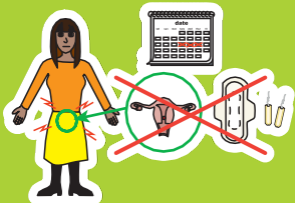
Do you have a change in colour to your breasts or nipples?

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

Do you get tired more easily?

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

https://assets.publishing.service.gov.uk/media/649d988606179b00113f7569/An_easy_guide_to_breast_screening_June23.pdf



Menopausal symptoms

Yes ✓	No ✗
<input type="checkbox"/>	<input type="checkbox"/>

Comments

Do you feel tired?

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

Do you have mood swings?

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

Do you feel sad?

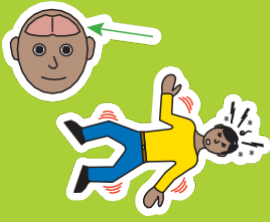
<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

Do you feel irritable?

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

Do you have hot flushes?

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------



Brain

Yes ✓	No ✗
<input type="checkbox"/>	<input type="checkbox"/>

Comments

Do you have epilepsy?

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

How many seizures per month?

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

Any changes to seizure?

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

Under the care of an epilepsy specialist(neurologist)

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

When did you last see them?

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

Triggers for Epilepsy e.g. lights, TV, tired , temperature, infections

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

Do you take your epilepsy medication regularly & as prescribed?

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

Do you have any side effects i.e. dizzy, sick, vision, irritable?

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

Have you had any of the following:

Stroke

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

Fainting

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

Blackouts

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

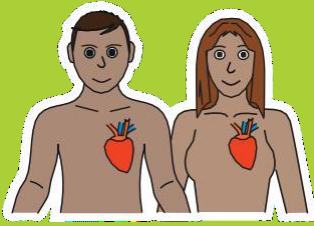
Pins and needles

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

Arm or leg weakness

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

Please bring your seizure chart with you, if you have one.



Heart

Yes ✓	No ✗
<input type="checkbox"/>	<input type="checkbox"/>

Comments

Difficult or labored breathing during the day and at night

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

Chest pain when exercising

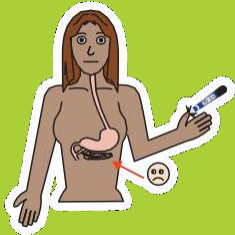
<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

Palpitations – feeling your heart beat

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

Any swelling to the ankles, hands or body?

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------



Diabetes

Yes ✓	No ✗
<input type="checkbox"/>	<input type="checkbox"/>

Comments

Do you test your blood sugar regularly?

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

Please bring your blood sugar charts if you have them

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

Do you have any problems with your eye sight?

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

Have you been for your diabetic eye screening?

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

When you have eye screening, we put drops in your eyes and take photographs of them.



Pain

Yes ✓	No ✗
<input type="checkbox"/>	<input type="checkbox"/>

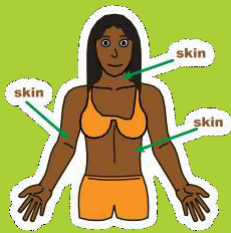
Comments

Do you have any pain?

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

Does your pain relief medicine help to stop or reduce the pain?

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------



Skin

Yes ✓	No ✗
<input type="checkbox"/>	<input type="checkbox"/>

Comments

Dry or Itchy Skin

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

Prescribed Skin Cream

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

Warts

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

Cold Sores

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

Sores or open wounds

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

Pressure area concerns

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------



Mental Health

Yes ✓	No ✗
<input type="checkbox"/>	<input type="checkbox"/>

Comments

Any Worries about your Memory or confusion

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

Are you low, sad or unhappy?

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

Are you worried, frightened or anxious?

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

Do you feel like crying?

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

Have you injured yourself since your last review?

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

Do you feel like you can't cope or look after yourself?

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

Do you feel irritable, aggressive or violent?

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

Have you thought about harming yourself or actually harmed yourself?

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

Do you hear voices or see things?

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

Have you spoken to someone to about how you feel?

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------



Feet

Yes ✓	No ✗
<input type="checkbox"/>	<input type="checkbox"/>

Comments

Have you been to a podiatrist (foot specialist)? When did you last go?

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

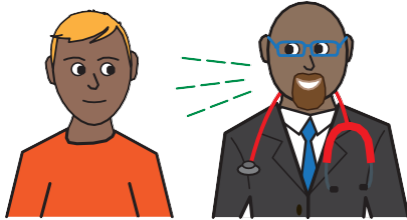
If no, who cuts your nails?

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

Do you have any pain in your feet?

<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------

Medication Review



Your Doctor will talk to you about your medication and look at whether your medication is right for you.

People with a learning disability are sometimes given medication they don't need; your doctor will talk to you if he needs to change yours.



Do you take your meds or does someone give them to you?
Are they in a box or do you dispense?
Can you swallow a tablet?
Do you need liquid medication?



.....

.....

Please bring a list of your medication with you



Hospital Passport

Yes ✓	No ✗
<input type="checkbox"/>	<input type="checkbox"/>

Comments

Do you have a hospital Passport?
This helps hospital staff understand how to help you

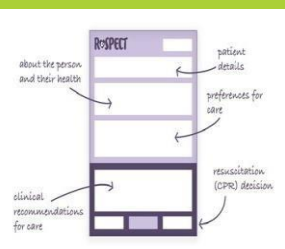
<input type="checkbox"/>	<input type="checkbox"/>
--------------------------	--------------------------



Palliative Care

Comments

Are you receiving support from palliative care services like a hospice or Marie Curie Nurse?



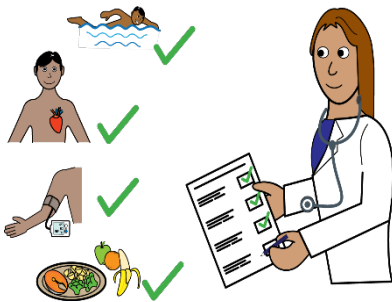
End of Life Gold Standard Framework

Comments

Do you have a 'DNAR' (Do Not Attempt Resuscitation) or 'ReSPECT' Document. Any concerns or questions about these documents?

<https://www.resus.org.uk/respect>

Bring a helper



You can ask questions at your health check.

You can bring someone with you who can help you in the appointment. You can decide if they will stay with you for some or all of the appointment.

Do you have any questions?





At the end of your Annual Health Check you should receive a copy of your Health Action Plan.

Did you receive yours?

Yes	No
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>



Thank you for completing this form.

Please bring it with you to the health check appointment along with any other important documents