

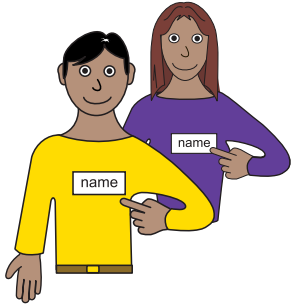


get checked out

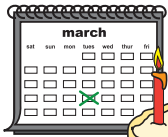
Get Checked Out Check List

About you

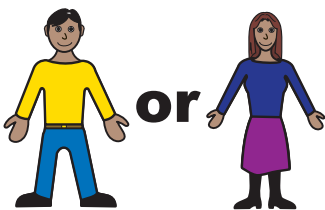
Please fill this book in and bring it back to the GP surgery



Name:



Date of birth:



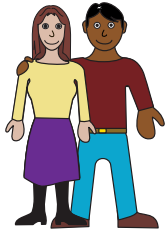
or



male



female



Are you married,
single,
divorced or widowed?



Address:
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.....



Email:
Tel:
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Next of kin:

Relation:

Address:

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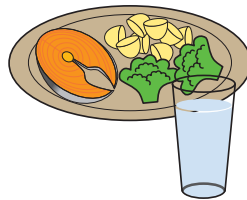
Tel:

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Medication
list

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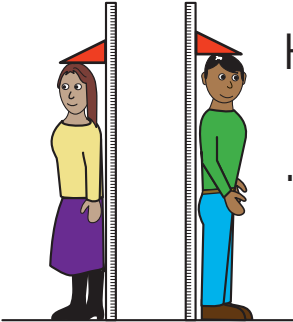
How do you take your
medication?

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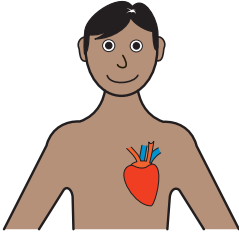


Eating and drinking	yes ✓	no ✗	comments
 Indigestion – tummy ache when you eat			
Food allergies/intolerances			
Being sick			
Do you drink alcohol			
Do you eat inedible food?			
Difficulty swallowing			
Coughing when eating or drinking			

	<p>Has your weight changed</p> <p>Please bring your weight chart if you keep one</p>	yes ✓	no ✗
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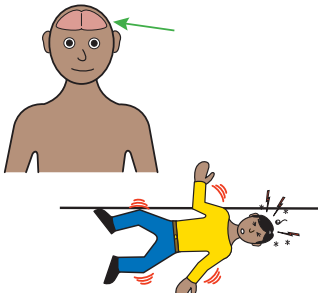


	<p>Height</p> <p>.....</p>
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Breathing 	yes 	no 	comments
Coughing that won't go away (more than 3 weeks)			
Chest infection			
Coughing up blood			
Unusual coloured spit			
Wheeze			
Hay fever allergies asthma, chronic obstructive pulmonary disease			
Breathlessness			
Do you smoke?			

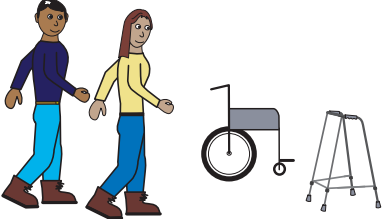


Heart 	yes 	no 	comments
Chest pain			
Swelling of the ankles			
Palpitations – feeling your heart beat			

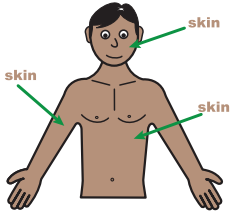




Brain 	yes 	no 	comments
Do you have epilepsy			
How often/number per month - changes?			
Under the care of epilepsy specialist (neurologist)			
When last seen			
Faints/blackouts/stroke passing out			
Pins and needles			
Arm or leg weakness			




Please bring epilepsy charts if you keep them.



Mobility 	yes 	no 	comments
Stiffness or difficulty moving			
Slowing of movements			
Pain when moving			
Falling or tripping			
Changes in posture/mobility			
Mobility equipment used			
Swelling or redness in limbs			
occupational therapy or physiotherapy input			

Skin 	yes 	no 	comments
Dry or itchy skin			
Prescribed skin cream			
Warts			
Cold sores			
Sores or open wounds			
5 Pressure area concerns			

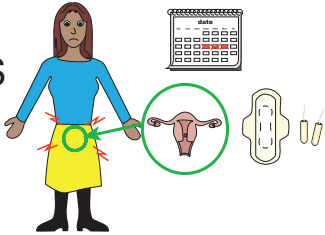




 Urine	yes 	no 	comments
Pain when you wee?			
Urine infection			
Wee more often?			
Blood in your wee?			
Difficulty in getting to the toilet in time?			

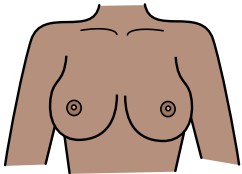


 Bowels	yes 	no 	comments
Constipation – hard poo or can't go to the toilet			
Diarrhoea – watery poo and going too much			
Bleeding from your bottom			
Difficulty getting to the toilet on time			
Changes in bowel pattern			

Please bring your bowel chart if you keep one.

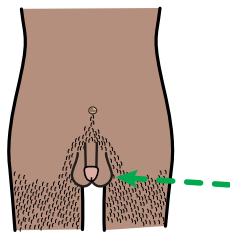


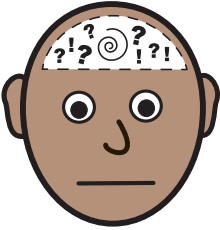
Women's health 	yes 	no 	comments
Change in periods i.e. heavy, bleeding in between painful etc			
Vaginal discharge			
Is contraception needed			
Are you sexually active? Contraception used?			

Please bring your menstruation chart if you have one

Breasts 	yes 	no 	comments
Lump in breasts (or any other concern about breasts)			
Discharge from nipples			
Pain or tenderness unusual shape, skin puckering or lumps			






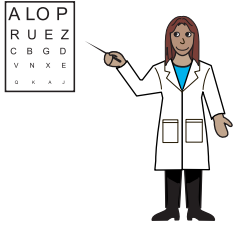


Men's Health	yes ✓	no ✗	comments
			
Testicular lump/swelling/changes			
Difficulty having a wee			
Are you sexually active?			
Contraception used?			

Mental Health	yes ✓	no ✗	comments
			
Any diagnosis			
Any worries about memory/ confusion			
Any change in behaviour since last review e.g. aggression, self-injury, over-activity			
Are you aware of any risk to the patient or others			
If yes, have you spoken/referred to other health and social care professionals			



You can ask questions at your health check

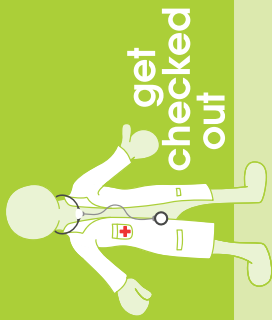
	yes 	no 	comments
Do you go to the dentist regularly?			

	yes 	no 	comments
Do you go to the optician regularly?			
Do you have any eyesight problems?			



Thank you for completing this form.

Please bring it with you to the health check appointment.



Health Action Plan

Name:

Date of health check:

Health Issue	Action Needed	Who will do it	Review Date