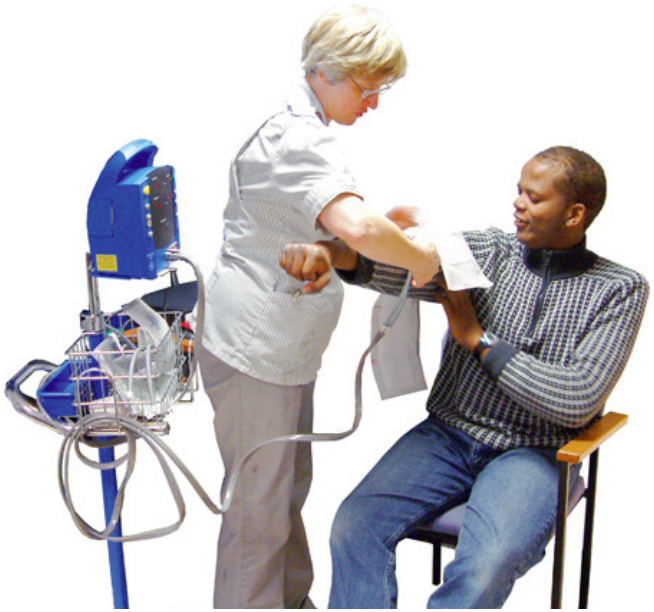
Bexley NHS Care Trust

Greenwich NHS Teaching Primary Care Trust

Oxleas NHS NHS Foundation Trust

Before I see the Nurse… Checking my health needs for my Health Action Plan

(This is Confidential)



This health check tool has been adapted from that used by Westminster PCT.

Getting a Health Action Plan

Fill out this form and **keep it safe**. You might need to ask someone to help you fill out this form.

You only have to fill in boxes with this purple colour

Take this form with you when you go and see your doctor or your nurse for your annual health check.

Staff at the GP surgery will fill in boxes this green colour

You also need this form when you complete your health action plan.

The nurse or doctor might tell other people about you so that they can help you to stay healthy. They will tell you about this first so that you can decide what you want to do.

Please fill in boxes with this purple colour

Preparation for a Health Action Plan

My Name is:

Do you have support from the Mental Health team?

My Care Manager is:

Other important people:

My Carer is:

Other important people:

My Health Facilitator is:

Other important people:

Please fill out these boxes.

Please ask the GP practice to fill out these green boxes for your Health Action Plan when you go for your check.

Remember to bring a urine sample.

For office use only. Please circle:

Urine glucose test negative
Urine glucose test trace
Urine glucose test +
Urine glucose test++
Urine glucose test +++
Urine glucose test ====
Glycosuria

How much alcohol do you drink?

Advice:

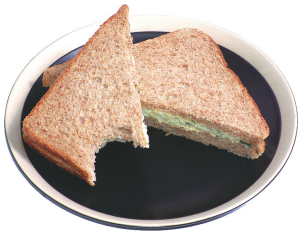
Are you registered with a dentist? If yes, who is it?

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

Date:

Any dental issues you want to tell us about:

Advice:



What did you eat yesterday?
Breakfast:

Lunch

Dinner:

Snacks:

Diet:
Do you often choke on your food?

Yes ☐ No ☐

Dietician:
Have you seen a dietician?

Yes ☐ No ☐

Advice:

Diet:
Do you follow a special diet?

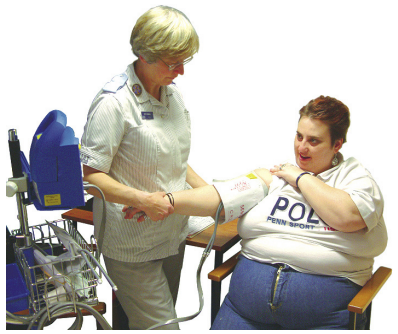
Who is your dietician?

The practice will now take some important measurements:

Weight:

BMI:

Height:



Blood Pressure:

Pulse:

Have you ever smoked?

Yes ☐ No ☐

How many do you smoke?

Advice:

Did you ever live in a hospital?

Yes ☐ No ☐

Do you know your Hepatitis A status?

Yes ☐ No ☐

Do you know your Hepatitis B status?

Yes ☐ No ☐

If, yes do you know your Tuberculosis status?

Yes ☐ No ☐

The nurse might check your blood

The nurse will check if you had a flu jab.

The nurse will check if you need a pneumococcal jab.

THIS PAGE IS FOR WOMEN ONLY

The nurse will ask you questions about your body and what you know about sex. This is to make sure that you are offered the right check ups to help you stay healthy.

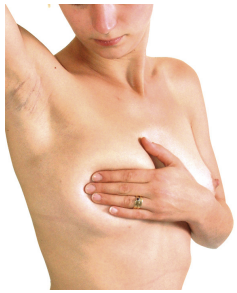
Have you ever had a smear test?

Yes ☐ No ☐

Do you know about smear tests?

Yes ☐ No ☐

Advice:



Do you know how to check your breasts?

Yes ☐ No ☐

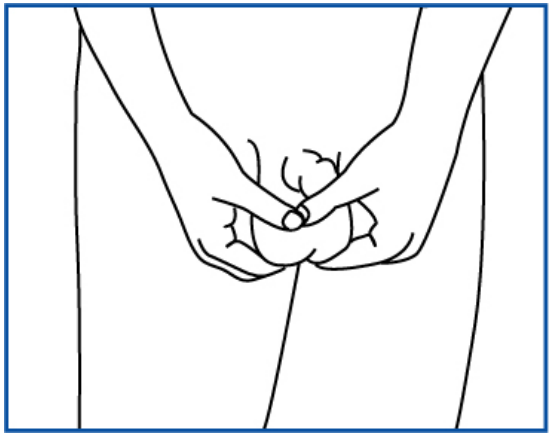
Have you ever had a breast screen?

Yes ☐ No ☐

If you had a breast screen, when was it?

THIS SECTION IS FOR MEN ONLY

The nurse will ask you questions about your body and what you know about sex. This is to make sure that you are offered the right check ups to help you stay healthy.



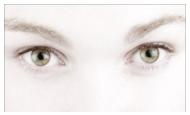
Do you know how to check your testicles?

Yes ☐ No ☐

Advice:

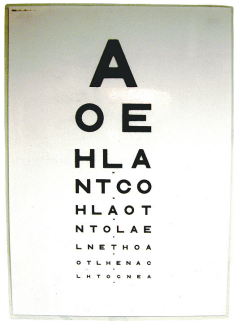
Do you wear glasses?

Yes ☐ No ☐



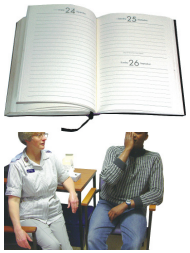
Do you eyes hurt?

Yes ☐ No ☐



Have you had an eyes test?

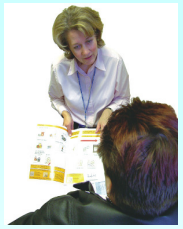
Yes ☐ No ☐

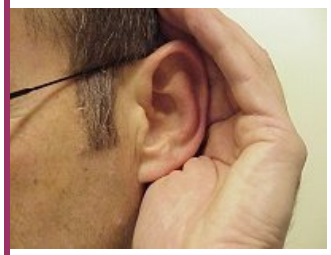


When and by whom?

Tell us if there have there been changes to your eyes that you are concerned about?

Advice:





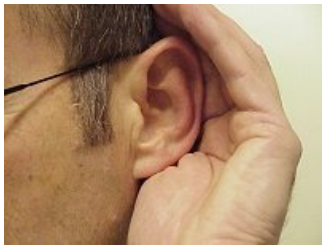
Have you had a hearing test?

Yes ☐ No ☐

When and by whom?

Have you got a hearing aid?

Yes ☐ No ☐



Has anyone commented that you might have a hearing problem?

Yes ☐ No ☐

Is there anything that you want to tell us about your ears?

The nurse will look into your ears.

Advice:

Do you have difficulties urinating?

Yes ☐ No ☐

Do you find it difficult going to the toilet on time?

Yes ☐ No ☐

Do you use any equipment?

Yes ☐ No ☐ What do you use?

Is there anything else you want to tell us?

Advice:

How are you feeling?

Do you get upset easily?

Yes ☐ No ☐

Are you worried about anything?

Yes ☐ No ☐

Are worries stopping you doing the things you want to do?

Yes ☐ No ☐

Do you sometimes feel like hurting yourself or others?

Yes ☐ No ☐

Are you on a CPA?

Yes ☐ No ☐

If you are on a CPA, who is your Care coordinator?

Have you ever seen a psychiatrist?

Yes ☐ No ☐

Advice:

Anything else you want to tell us?

Are you physically active?

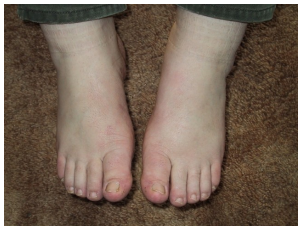
Yes ☐ No ☐

Do you have difficulties walking?

Yes ☐ No ☐

Do you have difficulties moving your arms?

Yes ☐ No ☐



Are you seeing someone for your feet?

Yes ☐ No ☐

Who are they?

Yes ☐ No ☐

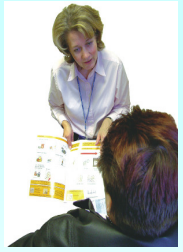
Do your feet itch or hurt?

Yes ☐ No ☐

Can you cut your own toenails?

Yes ☐ No ☐

Advice:



Anything else you want to tell us?

Do you have Epilepsy?

Yes ☐ No ☐

How many seizures do you have a month?

Do you know what your seizures are called?

When did you last check that your medication is working?

Who is your epilepsy doctor?

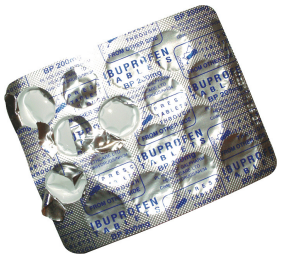
Anything else you want to tell us?

Advice:

Do you have any illnesses or conditions that stop you doing the things you like to do? Please tell us:

Have you ever had to stay in hospital overnight? Please tell us:

Advice:



Please list all your medication and bring these along:

Advice:

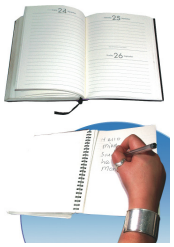
Have you got a health action plan, please bring it along:

Yes ☐ No ☐

Do you want a health action plan?

Yes ☐ No ☐

How would you describe yourself? (Ethnicity)



Date and Signature: