The Lewisham Care Partnership

Getting Ready for Your Annual Health Check

Please fill in this form so that
we can make the most of your appointment.

Hand it to the receptionist before you come to your appointment.

Or

Keep a copy with you if you are having your appointment by phone or on the computer.

Your General Health:

Do you smoke?

Yes　　No　　Given up

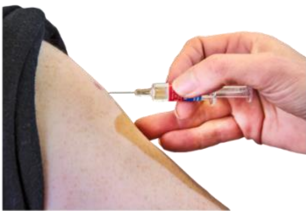
If YES, how many cigarettes a day?

5 -10　　10-20　　20-40

Do you drink alcohol?

Yes　　No

If YES, what do you drink and how much a week?



Date of last vaccination?

Tetanus

Hepatitis B

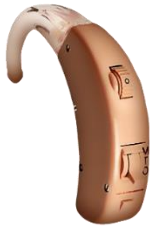
Flu

Pneumonia

Your Ears and Eyes:

Do you have a problem with hearing?

Yes | A little | No



Do you wear a hearing aid?

Yes | No

When was your last hearing test?

☐ Not had one

☐ Less than a year ago

☐ More than a year ago

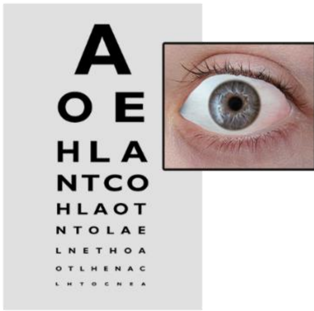
Do you have any problems with your eye-sight?

Yes | A little | No

Do you wear glasses?

Yes | No

When was your last eye test?



- ☐ Not had one
- ☐ Less than a year ago
- ☐ More than a year ago

Your Mobility:

Are you able to walk?

Yes | A little | No

Do you use walking aids such as a frame?

Yes | No

Do you use a wheelchair?

Yes | No

When was your last mobility assessment?

- ☐ Not had one
- ☐ Less than a year ago
- ☐ More than a year ago

Your Breathing:

Can you breathe easily without problems?

Yes No

Do you have a cough?

Yes No

Do you cough anything up?

Yes No

If YES, what?

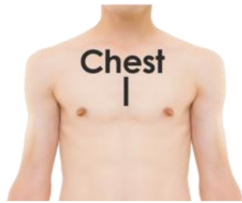
....

....

Is there any blood in what you cough up?

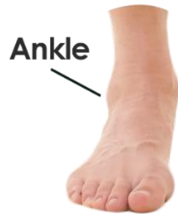
Yes No

Your Heart:



Do you have any pains in your chest?

Yes　　No



Are your ankles swollen?

Yes　　No

Do you feel dizzy or faint when you stand up?

Yes　　No

Your Stomach and Bowels and Going to the Toilet:

Have you lost weight in the last 6 months?

Yes　　No

Eat

Do you have any pain after eating?

Yes　　No

Are you being sick?

Yes　　No

Do you have any problems eating or swallowing?

Yes No

Your Bowels:

Do you find it hard to do a poo?

Yes No

Is your poo soft and runny?

Yes No

Do you have any blood in your poo?

Yes No

Your Bladder:

Do you have pain when you wee?

Yes No

Do you feel like you want to wee very often?

Yes No

Do you have blood in your wee?

Yes No

Do you ever wet yourself?

Yes No

Women's Matters:

When was your last period?

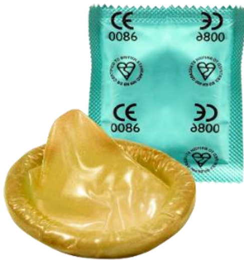
Date …../…../…..

Are your periods painful?

Yes No

Is there any bleeding between your periods?

Yes No



Do you use any form of contraception?

Yes No

Do you have any itching or liquid coming from your private parts?

Yes No

Do you have lumps in your boobs?

Yes No

Men's Matters:

Do you have lumps or pain in your testicles (balls)?

Yes No

How You Feel:

Do you feel angry of cross?

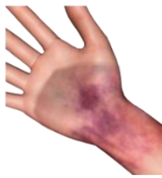
Yes No

Do you feel sad?

Yes No

Do you feel worried or scared?

Yes No



Do you ever hurt yourself on purpose?

Yes No

Support You Have:

Live on your own

Live with family

Live with friends

I live with a foster carer

Live in supported property

Live in residential care

Work You Do:

Have a full time job ☐

Have a part time job ☐

Looking for a job ☐

Retired ☐

Student ☐

Unable to work ☐

Other (tell us)……………………………..………

……………………………………………………………

Is there anything you would like to talk about during your health check?

Do you have support from a paid carer, social worker, health worker or specialist team?

Yes ☐ No ☐