**Please fill in this form and take it to your Learning Disability Annual Health Check. You can ask your carer to help.**

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| --- | --- | --- |
| **[Vape Out 1](https://www.photosymbols.com/collections/health/products/vape-out-1?_pos=18&_sid=97d5d1d7a&_ss=r)Do you smoke or vape?** | Please **circle** your answer  Yes No | If you said yes, write the **number of cigarettes** you smoke a day. Or **number of times** you vape |
| **Do you drink alcohol?** | Please **circle** your answer  Yes No | If you drink alcohol write down **what** you drink. **How much** do you drink a week? |
| **Do you eat healthy foods?** | Please **circle** your answer  Yes No | Write down what **foods** you **like** to eat |
| **Do you exercise?** | Please **circle** your answer  Yes No | Write down what **exercise** you do.  **How often** do you exercise? |
| **Do you take drugs?** | Please **circle** your answer  Yes No | If you said **yes**, write what **drugs** you take. **How often** do you take drugs? |
| **Learning Disability Care​ | Disability Live-in Care SupportDo you have carers?** | Please **circle** your answer  Yes No | Carers name………………………………………..  Carers telephone number…………………….. |
| **Do you get help from health or social care workers?** | Please **circle** your answer  Yes No | If **yes**, then please give their **details**:  Name………………………………………………………  Job title…………………………………………………..  Name……………………………………………………..  Job title………………………………………………….. |
| **Do you work?** | Please **circle** your answer  Yes No | If you work, what **job** do you have? |
| **How I spend my time** | Please **circle** your answer  Am I **busy**?  Yes No | Write down what **activities** you do, for example day services, work and hobbies |
| **Reasonable adjustments** | Please **circle** your answer  Do you need **reasonable adjustments?**  Yes No | Write down what **reasonable adjustments** you need when going to health services |
| **Movement** | Please **circle** your answer  Do you **walk**?  Yes No  Do you use a **walking aid**?  Yes No  Do you use a **wheelchair**?  Yes No  Do you **fal**l?  Yes No | Please write **extra information** here |
| **Daily Living** | Please **circle** your answer  Do you need help with **everyday tasks?**    Yes No | Write down what **help** you need and  **who** helps you? |

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| **Eye test** | **Dental check** | **Podiatry** | **Hearing test** | **Screening:**  **Breast Smear test, Bowel** | **Other appointments** |
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| **Do you have anything else you want to talk to the Doctor or Nurse about? Write them down inside this box** |

Write the date of your last appointments in the white box above