Partners

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Oakmeadow Surgery NHS Health Check

Name____ Male / Female DOB:____________

Am I eligible for an NHS Health Check? The check is for people who are aged 40 to 74 who do not have any of the following pre-existing conditions: (please tick)	
Heart disease (such as heart attack, heart failure, atrial fibrillation or angina)	
Stroke, transient ischaemic attack or peripheral vascular disease	
Diabetes or high blood pressure (hypertension)	
Currently being prescribed statins to lower cholesterol	
Chronic kidney disease	
Or You have already had a NHS Health Check within the last 5 years	
If you have ticked any of these boxes there is no need to complete this form, please speak to your GP to ensure you are having the appropriate annual checks.	

Ethnicity (please tick) It is important for us to know this as risks for some disease's changes depending on your ethnicity			
White British		Indian or British Indian	
White Irish		Pakistani or British Pakistani	
Other White background		Bangladeshi	
Caribbean (Black / Black British)		Chinese	
African (Black /Black British)		Other Asian ethnicity	
Other Black background		Other ethnicity (please feel free to specify)	
Mixed ethnicity			

Family History This applies to your 1st degree relative i.e. father, mother, brother, or sister only. (please tick)	
Family history not known (adopted)	
Heart attack diagnosed when less than 55 years in male relative	
Heart attack diagnosed when less than 65 years in female relative	
Angina diagnosed when less than 55 in male relative	
Angina diagnosed when less than 65 in female relative	
Stroke diagnosed when less than 55 in male relative	
Stroke diagnosed when less than 65 in female relative	
High cholesterol	
High blood pressure (Hypertension)	
Mental health (please specify which type)	
Cancer (please specify which type)	
No family history of conditions listed above	

You can obtain the following measurements by recording these at home, in your local pharmacy or at in reception area.	
Height:	Weight:
Blood Pressure: /	Pulse:
Please also drop in a urine sample and mark on the form that this is for a 'NHS Health Check'	

General Practice Physical Activity Questionnaire (GPPAQ) (please tick) 1. Please tell us the type and amount of physical activity involved in your work.	
I am not in employment (e.g. retired, retired for health reasons, unemployed, full-time carer etc.)	
I spend most of my time at work sitting (such as in an office)	
I spend most of my time at work standing or walking. However, my work does not require much intense physical effort (e.g. shop assistant, hairdresser, security guard, child-minder, etc.)	
My work involves definite physical effort including handling of heavy objects and use of tools (e.g. plumber, electrician, carpenter, cleaner, hospital nurse, gardener, postal delivery workers etc.)	
My work involves vigorous physical activity including handling of very heavy objects (e.g. scaffolder, construction worker, refuse collector, etc.)	

General Practice Physical Activity Questionnaire (GPPAQ) (please tick one box only on each row) 2. During the last week, how many hours did you spend on each of the following activities?				
	None	Some but less than 1 hour	1 hour but less than 3 hours	3 hours or more
Physical exercise such as swimming, jogging, aerobics, football, tennis, gym workout etc.				
Cycling, including cycling to work and during leisure time				
Walking, including walking to work, shopping, for pleasure etc.				
Housework/Childcare				
Gardening/DIY				

General Practice Physical Activity Questionnaire (GPPAQ) (please tick one box only) 3. How would you describe your usual walking pace?							
Slow pace (i.e. less than 3 mph)		Steady average pace		Brisk pace		Fast pace (i.e. over 4mph)	

Smoking (please tick)			
Smoker		Heavy Smoker (20-39 cigs/day)	
Light Smoker (1-9 cigs/day)		Ex-smoker	
Moderate Smoker (10-19 cigs/day)		Never smoked tobacco	
Would you like support to stop smoking?			
If you take any other drugs (recreationally i.e cannabis, etc) or regular drugs (over the counter from the pharmacy i.e. for indigestion, piles, pain medications) please tick this box and speak to your GP)			

Mood related questions (please tick)	
During the last month have you been feeling down, depressed or hopeless?	
During the last month have you often been bothered by having little interest or pleasure in doing things?	
If you are over 65 are you aware of signs of dementia?	
If you are over 65 and would you like more information about dementia and support available?	

Do you drink Alcohol	Yes/No	How many units per week (see below)? ______________

ALCOHOL SCREENING TOOL

UNIT GUIDE

1 unit is typically:

Half-pint of regular beer, lager or cider; 1 small glass of low ABV wine (9%); 1 single measure of spirits (25ml)

The following drinks have more than one unit:

A pint of regular beer, lager or cider, a pint of strong /premium beer, lager or cider, 440ml regular can cider/lager, 440ml "super" lager, 250ml glass of wine (12%)

The following questions are validated as screening tools for alcohol use

AUDIT- C Questions	Scoring system					Your score
	0	1	2	3	4	
How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times per month	2-3 times per week	4+ times per week	
How many units of alcohol do you drink on a typical day when you are drinking?	1 -2	3-4	5-6	7-9	10+	
How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
					TOTAL :	

If the total score is five or above please complete the questionnaire below

AUDIT Questions (after completing 3 AUDIT-C questions above)	Scoring system					Your score
	0	1	2	3	4	
How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you failed to do what was normally expected from you because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you been unable to remember what happened the night before because you had been drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Have you or somebody else been injured as a result of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?	No		Yes, but not in the last year		Yes, during the last year	
					TOTAL	

If the total score is eight or above it might be useful to discuss alcohol consumption further.

WHAT TO EXPECT NEXT: Once you have completed this form please return it to the practice. We will then review it and determine if you require any further discussions, investigations such as blood test or referrals, which we will contact you to arrange.