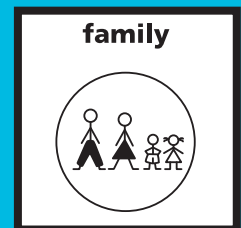
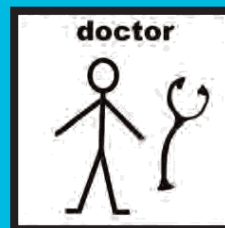
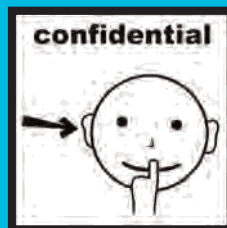


# My Health Record





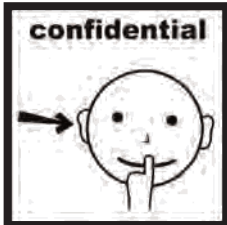
# Introduction

This booklet is about my health. It gives information that will be helpful to people who do not know me so that they can provide me with the right support when I need it.

With support I can use this information to write a Health Action Plan

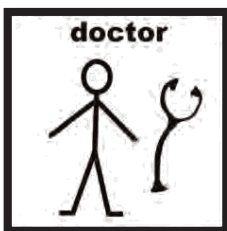


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## 3 Important information

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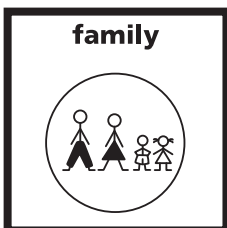
## 4 My medication

Page 15



## 5 Immunisations

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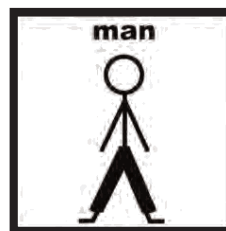
## 6 Family history

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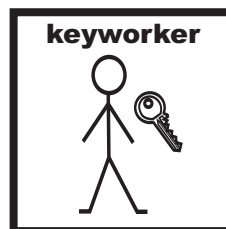
## 8 For Men

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## 9 For Women

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## 10 People who help me

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## 11 Contact Details

Back Cover

**myself**



# About me

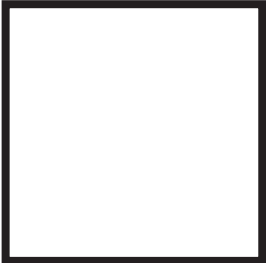
A large, empty rectangular box with a thin black border, intended for a photograph.

My photographs

A large, empty rectangular box with a thin black border, intended for a photograph.A large, empty rectangular box with a thin black border, intended for a photograph.



# Personal Information 1



My name is .....



address

My address is .....

.....

.....



phone

My telephone number is .....

My Date of Birth is .....

My Marital Status is .....

My Religion is .....



# Personal Information 2

I like to be called .....

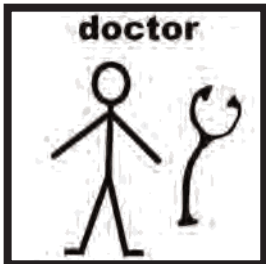


My Next of Kin is .....

Their address and telephone number is .....

.....

.....



My Doctor is .....

Their address is .....

.....

.....



Their telephone number is .....





# Personal Information 3

families  
carers



My Main Carer is .....

Their address and telephone number is .....

.....

.....

address



advocacy



My Advocate is .....

Their address and telephone number is .....

.....

.....

address

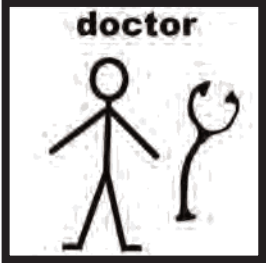


My NHS Number is .....


My National Insurance Number is .....




# Visiting the Doctor 1



When I visit the GP I prefer to see a Doctor who is:





I need support when having



Blood Pressure checked?

YES

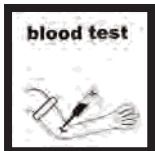
NO



My temperature taken?

YES

NO



Blood samples taken?

YES

NO



Injections?

YES

NO



Examinations?

YES

NO





# Visiting the Doctor 2

This is what I think and feel about going to the Doctors:

.....

.....

.....

.....

I would like support staff to remember the following when supporting me at the Doctors:

.....

.....

.....

.....

.....

.....

.....

.....

doctor



# Visiting the Doctor 3

I went to the Doctors on:	We discussed the following:



# About my Health

I have other health needs that would be useful for you to know about, eg: allergies:

YES     NO

These are:.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....



# Important information about me & my health 1

I communicate:

- Verbally
- Using spoken language
- Using signs (eg: Makaton)
- Using signs, pictures and symbols
- Using gestures and noises
- Using eye pointing
- Other methods (specify) .....

.....

.....

.....



# Important information about me & my health 2

People know if I am unwell if: .....

.....

.....

.....



I get help if I am unwell by: .....

.....

.....

.....

You can best support me when I am unwell by: .....

.....

.....

.....



# Important information about me & my health 3

I am able to understand information if it is:

- Written word
- In symbol form
- In picture form
- Communicated verbally
- Interpreted by a carer
- Other methods (specify) .....

.....

.....

.....



# Important information about me & my health 4

I sometimes don't understand about Doctors or other medical appointments and this makes me anxious or nervous:

YES     NO

You can support me best by: .....

.....

.....

.....

.....

.....

.....

.....

.....

.....

.....

**medicine**



# My Medication 1

I prefer to take my medication in:

Tablets       Liquid       Other

**blood test**



I require blood tests to monitor my medication?

YES       NO

yes



If YES, how often? .....

I am allergic to some medication?

YES       NO

yes



If YES, which ones? .....

.....

**date**



When was my medication last reviewed? .....

.....



medicine



# My Medication 2

The tablets/medicine I take are:	Prescribed by:	Date started:	Date stopped:	Date reviewed:

medicine



# My Medication 2

*continued*

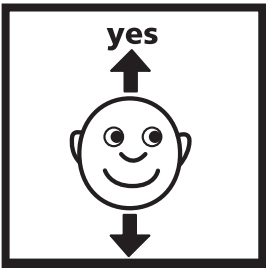
The tablets/medicine I take are:	Prescribed by:	Date started:	Date stopped:	Date reviewed:



# Important information about me & my health 5

## My Eyesight

I have problems with my eyesight?



YES  NO

If YES, please describe: .....

.....  
.....  
.....



My Optician's name, address and phone number is:

.....  
.....  
.....

I have regular eyesight tests?

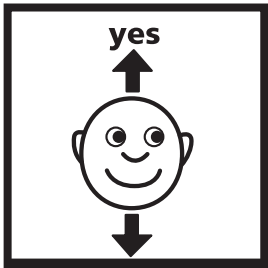
YES  NO



# Important information about me & my health 6

## My Hearing

I have problems with my hearing?



YES     NO

If YES, please describe: .....

.....  
.....  
.....

I have had a hearing test?     YES     NO

You can best support me with my hearing in the following ways: .....

.....  
.....  
.....  
.....



# Important information about me & my health 7

**brush teeth**



## My Teeth

I visit the Dentist regularly?

YES     NO

**address**



My Dentist's name, address and phone number is: .....

.....  
.....  
.....  
.....

I have problems with my teeth or gums?     YES     NO

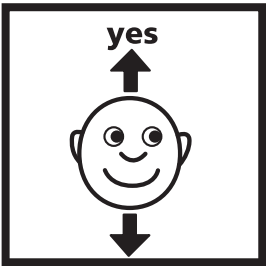
If YES, please describe: .....

.....

I see a dental hygienist?     YES     NO

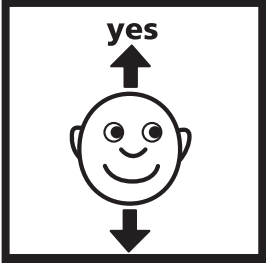
Who are they?: .....

.....





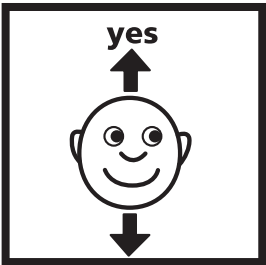
# Important information about me & my health 8



## My Skin

I have skin problems?

YES  NO



If YES, please describe: .....

.....  
.....  
.....

I see a specialist about my skin problems?  YES  NO



If YES, their name, address and phone number is: .....

.....  
.....

Support me with my skin problems by: .....

.....  
.....



# Important information about me & my health 9

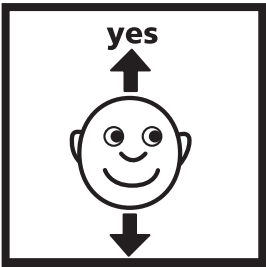
## My Feet

I have problems with my feet?

YES     NO

I see a Chiropodist?

YES     NO



If YES, their name, address and phone number is: .....

.....  
.....  
.....  
.....



Support me with my feet problems by: .....

.....  
.....  
.....



# Important information about me & my health 10

## Disability

My disability is described as: .....

.....

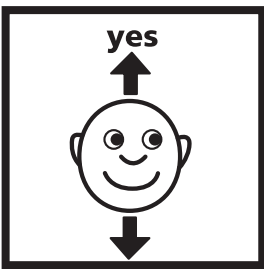
.....

The best way to support my disability is: .....

.....

.....

.....



I see an Occupational Therapist?

YES     NO

If YES, their name, address and phone number is: .....

.....

.....

.....

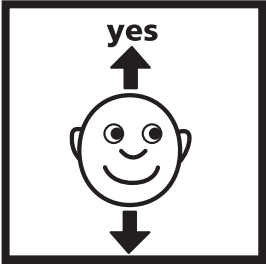






# Important information about me & my health 11

## Mobility



I need support to get around?

YES  NO

If YES, please describe: .....

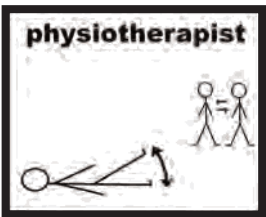
.....  
.....



I need special aids or adaptations to get around?  YES  NO

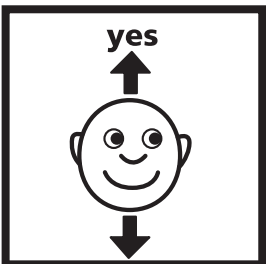
If YES, please describe: .....

.....  
.....



I see a Physiotherapist?  YES  NO

If YES, their name, address and phone number is: .....



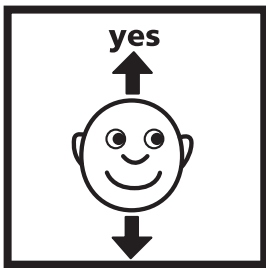
.....  
.....



# Important information about me & my health 12

## Epilepsy

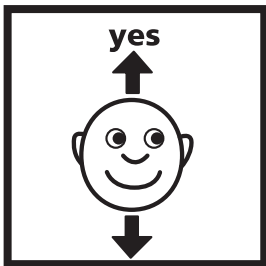
I have Epilepsy?



YES  NO

If YES, the type of seizures I have are: .....

.....  
.....



I see a consultant about my epilepsy?  YES  NO

If YES, their name, address and phone number is: .....



.....  
.....



I take the following medication to help control my epilepsy: .....

.....  
.....



# Important information about me & my health 13

## My Mental Health and Well Being

I have a diagnosed mental health need?

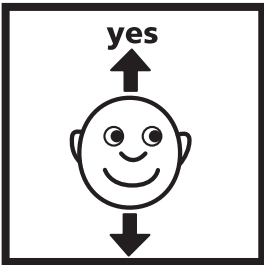
YES     NO

If YES, please describe: .....

.....

.....

.....



I see a Psychiatrist about my mental health?     YES     NO



If YES, their name and address is: .....

.....

.....



Information about my mental health: .....

.....

.....

.....



# Important information about me & my health 13 *continued*

## My Mental Health and Well Being *continued*

Support Staff can best support my  
mental health needs by: .....

.....

.....

.....

.....

If there are people or situations that make me anxious,  
unhappy or unsettled, I have described these here:

.....

.....

.....

.....

.....

**injection**



# Immunisations

	Date	Date of booster
Diphtheria		
Flu		
Measles		
Mumps		
Rubella		
Tetanus		
Hepatitis B		



# Family History 1

People in my family have had the following:

Heart problems?  YES  NO  DON'T KNOW

Diabetes?  YES  NO  DON'T KNOW

Asthma?  YES  NO  DON'T KNOW

Cancer?  YES  NO  DON'T KNOW

Glaucoma?  YES  NO  DON'T KNOW

High blood pressure?  YES  NO  DON'T KNOW

Mental health problems?  YES  NO  DON'T KNOW

Sickle Cell disorders?  YES  NO  DON'T KNOW



# General Health and Lifestyle

I smoke?  YES  NO

If YES, how many per day: .....

I live with others  
who smoke?  YES  NO

I want to give  
up smoking?  YES  NO  DON'T KNOW

I drink alcohol  YES  NO

If YES, how often?  Daily  Weekly  Less often

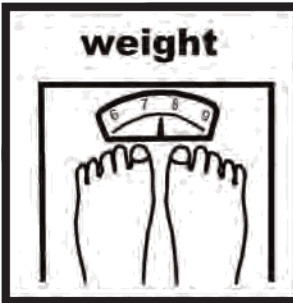
What do you drink? .....

.....

I like exercise?  YES  NO

I would like advice  
about exercise and health?  YES  NO





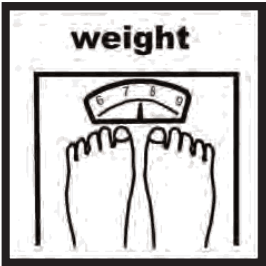
# General Health and Lifestyle 1



## Eating and Drinking

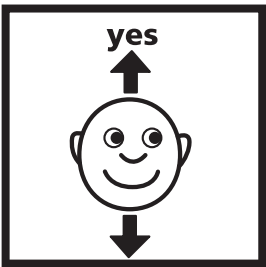
My weight is: .....

My usual or normal weight is: .....

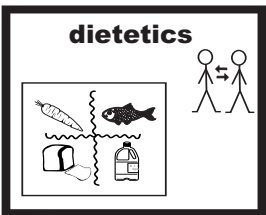


I need a special diet?  YES  NO

If YES, please describe: .....



.....  
.....  
.....

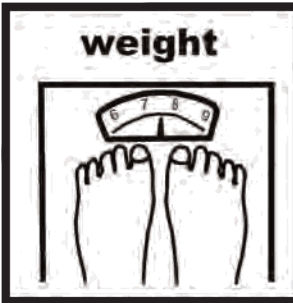


I see a Dietician about my weight or diet?  YES  NO

If YES, their name and address is: .....



.....  
.....  
.....



# General Health and Lifestyle 2



## Eating and Drinking *continued*

I would like advice about losing weight?  YES  NO

I have difficulties eating?  YES  NO

I have difficulties drinking?  YES  NO

Please describe your difficulties: .....

.....

.....

.....

.....

.....

.....

.....

.....



# General Health and Lifestyle 3



## Blood Pressure and Cholesterol

I have had my blood pressure checked?

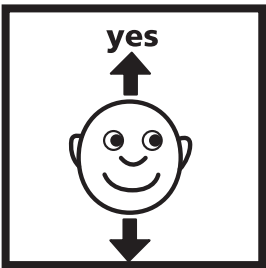
YES     NO

My normal BP is: .....

I have had my cholesterol checked?

YES     NO

If yes, what was it: .....





# For Men

I attend a well man clinic?

YES     NO



The address is: .....

.....

.....

I have been shown how to check for lumps in my testicles / balls?

YES     NO

I have been given information on safe sex and contraception?

YES     NO

I would like advice on safe sex and contraception?

YES     NO



# For Women

I attend a well woman clinic?  YES  NO

The address is: .....



.....

.....

I have regular smear tests?  YES  NO

I have been given information on safe sex and contraception?  YES  NO

I would like advice on safe sex and contraception?  YES  NO

I have had breast screening?  YES  NO

I have been shown how to check my breasts / tits?  YES  NO

I have problems with or irregular periods?  YES  NO



Information about specific women issues: .....

.....

help



# The people who help me with my health are:

Name: .....

Role: .....

Address: .....

.....

.....

Phone: .....

Email: .....

Name: .....

Role: .....

Address: .....

.....

.....

Phone: .....

Email: .....

help



# The people who help me with my health are:

Name: .....

Role: .....

Address: .....

.....

.....

Phone: .....

Email: .....

Name: .....

Role: .....

Address: .....

.....

.....

Phone: .....

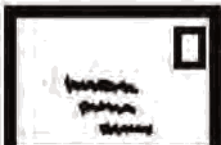
Email: .....

information



# Contact Details

write to



## Community Support Team

Learning Disability Service

Poplar House

St Mary's Hospital

Greenhill Road

Armley

Leeds

LS12 3QE

phone



Phone: 3055350

internet



Webpage:

[www.leedsmentalhealth.nhs.uk/services.asp?page\\_id=4&sub\\_id=44](http://www.leedsmentalhealth.nhs.uk/services.asp?page_id=4&sub_id=44)