**Learning Disability Questionnaire**

**About this Questionnaire**

This questionnaire will help the Doctor/nurse to get information about you. This information will hep them with your **annual health check**.

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| Q.1  | What is your name? |

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| HomeQ.2 | What is your address? |

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| DaysQ.3 | What is your date of birth? |

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| Mobile_phone1Q.4 | What is your telephone number?HomeMobileContact number in an emergency |

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| Clipboard_goodQ.5 | Please tick the box which best describes you**:** |
| Single |
| Married |
| Separated |
| Divorced |
| Widowed |

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| CigaretteQ.6 | Have you ever smoked? |
| Yes |
| No |
| Don’t know |

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| --- | --- |
| CigaretteQ.7 | Do you smoke now? |
| Yes If so how many a day |
| No |
| Don’t know |

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| Social_worker3Q.8 | Do you have a social worker? |
| YesIf yes what is their name? |
| No |

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| Q.9 | Do you have any problems with communication? |
| Yes |
| No |

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| Q.10 | Do you use a picture book or electronic prompt device? |
| Yes |
| No |

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| --- | --- |
| Q.11 | Do you need someone with you to help you communicate? |
| Yes |
| No |

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| Q.12 | Do you have a speech problem? |
| Yes |
| No |

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| --- | --- |
| Q.13 | Do you have a stammer/stutter? |
| Yes |
| No |

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| Q.14 | Do you use Makaton sign language? |
| Yes |
| No |

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| --- | --- |
| Q.15 | Do you need an interpreter? |
| Yes |
| No |

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| Q.16 | Do you have a carer? |
| YesWhat is there name? |
| No |
| Q.17 | Which best describes your ethnic origin? |
| White |
| Asian or Asian British |
| Black |
| Other |

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| --- | --- |
| Beer_pintQ.18 | How often do you have a drink containing alcohol? |
| Never |
| Monthly |
| Less than 2 – 4 times per month |
| 2 – 3 times per week |
| More than 4 times a week |

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| Fruit_bowl1Q.19 | What best describes your eating habits? |
| Healthy Diet |
| Diet Good |
| Diet Average |
| Diet poor |

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| --- | --- |
| RunQ.20 | What best describes your exercise habits? |
| Cannot exercise |
| Don’t like to exercise |
| Enjoy light exercise |
| Enjoys moderate exercise |
| Enjoys heavy exercise |
| Don’t know |

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| Q.22 | Do you have any problems swallowing? |
| No |
| Have difficulty swallowing solids |
| Have difficulty swallowing liquids |
| Have swallowing symptoms |

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| Q.22 | Do you have any feeding problems? |
| Yes |
| No |

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| --- | --- |
| Man_mouthQ.23 | Do you have any mouth symptoms? |
| No mouth problems |
| Sore gums |
| Bleeding gums |
| Good oral hygiene |
| Poor oral hygiene |

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| Teeth_clean1Q.24 | Are you registered with a dentist? |
| YesWhen was the last time you saw your dentist? |
| No |

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| Q.25 | Do you have a PEG feeding tube fitted? |
| Yes |
| No |
| Q.26 | Do you regularly suffer from constipation? |
| Yes |
| No |

|  |  |
| --- | --- |
| Q.27 | Do you regularly suffer from diarrhoea? |
| Yes |
| No |

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| --- | --- |
| Q.28 | Have you seen any blood in you poo? |
| Yes |
| No |

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| --- | --- |
| Q.29 | Do you have any bowel problems? |
| Yes |
| No |

|  |  |
| --- | --- |
| Q.30 | Do you have any bladder problems? |
| Yes |
| No |

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| --- | --- |
| Man_eyeQ.31 | Do you have normal vision? |
| Yes |
| No |

|  |  |
| --- | --- |
| Man_eyeQ.32 | Are you registered partially sighted? |
| Yes |
| No |

|  |  |
| --- | --- |
| Man_eyeQ.33 | Are you registered blind? |
| Yes  |
| No |
| Man_eyeQ.34 | Are you registered sight impaired? |
| Yes |
| No  |

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| --- | --- |
| Man_eyeQ.35 | Do you suffer from poor vision? |
| Yes |
| No |

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| --- | --- |
| Q.36 | Do you wear glasses? |
| Yes  |
| No |

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| --- | --- |
| Q.37 | Should you wear glasses but don’t? |
| Yes |
| No  |

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| EyetestQ.38 | Have you been seen by an optician? |
| YesPlease tell us when |
| No |

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| --- | --- |
| Listen2Q.39 | Do you have normal hearing? |
| Yes  |
| No |

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| --- | --- |
| Listen2Q.40 | Do you have hearing difficulties? |
| Yes |
| No |

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| --- | --- |
| Listen2Q.41 | Are you deaf in one ear? |
| Yes  |
| No  |

|  |  |
| --- | --- |
| Listen2Q.42 | Are you deaf in both ears? |
| Yes |
| No |

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| --- | --- |
| Listen2Q.43 |  Are you partially deaf? |
| Yes |
| No |

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| --- | --- |
| Hearing_aidQ.44 | Do you wear a hearing aid? |
| Yes |
| No |

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| --- | --- |
| Man_ear2Q.45  | Have you been seen by an audiologist? This person looks after your ears. |
| YesIf so please tell us when |
| No |

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| Q.46 | Do you have epilepsy? |
| Yes |
| No |

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| --- | --- |
| Q.47 | If you have epilepsy, is it well controlled: |
| Yes |
| No  |
|  |
| How often do you have a fit? |
| Last 12 months no seizures |
| No seizures on treatment |
| 1 – 12 seizures per year |
| 2 – 4 seizures a month |
| 1 – 7 seizures a week |
| Seizures every day |
| Lots of seizures a day |

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| Q.48 | When did you have your last fit? |

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| Sleep2Q.49 | Do you have any problems sleeping? |
| Yes |
| No |

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| Clipboard_goodQ.50 | Please tell us which statements best describes you: |
| I am fully mobile |
| I am mobile outside of my house but need an aid |
| I am mobile in my house |
| I need a walking aid in my house |
| I am confined to a chair |
| I have impaired mobility |
| I am housebound |
| I am temporarily housebound |

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| Jobs_paperQ.51 | Do you have a paid job? |
| YesIs this full time yes/no |
| No |

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| Q.52 | Are you retired? |
| YesIs so were you retired on medical grounds yes/no |
| No |

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| Q.53 | Are you unfit for work? |
| Yes |
| No |

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| House5Q.54 | Please tell us which statements best describes how you live? |
| I live alone |
| I live with family |
| I live in a residential home |
| I live in a nursing home |
| I live in Independent Supported Living |

Thank you for completing this questionnaire.

Can you please send it to: