

NHS Health Checks Eligibility Questionnaire



Are you eligible for a NHS Health Check?

Gender Age Postcode

Name of GP or Practice Name

Tick as appropriate

Q1. Have you had a NHS Health Check in the past 5 years? Yes No

If **NO** proceed to Q2. If **YES** client is not eligible this time.

Tick as appropriate

Q2. Have you been diagnosed with the following?

Diabetes	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Hypertension	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Chronic Kidney Disease	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Angina	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Familial Hyperlipidaemia	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Atrial Fibrillation	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Peripheral Arterial Disease	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Or had ...				
A Stroke or Transient Ischemic Attack (TIA)	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Heart Failure	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Heart Attack (MI)	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>

If **NO** to any of the above, proceed to Q3. If **YES** to any of the above, client is not eligible.

Tick as appropriate

Q3. Do you take any of the following medication?

Blood thinning medication, anticoagulants (that are not for DVT)	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Anti platelets	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Hypertensive drugs	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Medication for cholesterol/statins/diabetes	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>

If **YES** to any of the above, resident is not eligible. If **NO** to all of the above please proceed to book resident in for Health Check.



Completed by Organisation