

# Health Action Plan



**Name:**

**Date of Birth:**

Private – to be kept safe.

# My Health Plan

**STOP** – have you had an annual health check from your doctor or nurse? You should have one of these before starting to fill this plan out.

**STOP** – you need to choose someone who will help you fill this plan out and help you to keep it up to date and support you in taking action:

## My Health Action Plan Supporter is:-

*Name:*

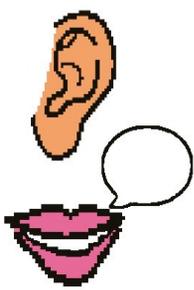
*Contact Details:*

You can use this plan to help you record information which is important and useful to you in managing your health and any long term conditions you may have.

## What it might help others to know about me:-

*This section is for recording details of my personality, likes and dislikes to help inform health professionals and others about how I like to be treated.*

## Personal Information

	Name: I like to be known as:
	Date of birth:
	Address:
	Telephone Number:
	NHS Number:
	Allergies:
	Ethnic origin / religion:
	My first language is / How I communicate :

<p>The main person involved in supporting my Healthcare:</p> <p>Telephone Number:</p>	<p>GP (Doctor):</p> <p>Address:</p> <p>Telephone Number:</p>
<p>Other people who know me well:</p>	<p>Telephone Number:</p>



## My Medication

<b>Medication</b>  	<b>What is the medication for?</b>	<b>Dose and Frequency</b> (How often do you take it?)	<b>When was this medication reviewed?</b>	<b>Date medication stopped</b>



# Diary of Health Appointments

## GP (Doctor) and Practice Nurse Appointments

GP name:

GP address:

GP phone number:

<b>Date</b>	<b>Time</b>	<b>Reason for attending</b> Why did you visit your GP?	<b>Report / Outcome</b> What happened? What issues were identified?
		<b>MY ANNUAL HEALTH CHECK</b>	
			5



## Diary of Health Appointments

### Dentist Appointments

Dentist name:

Dentist address:

Dentist phone number:

<b>Date</b>	<b>Time</b>	<b>Reason for attending</b> Why did you visit your Dentist?	<b>Report / Outcome</b> What happened? What issues were identified?



South West Essex

## Diary of Health Appointments

### Eye Appointments

Optician name:

Optician address:

Optician phone number:

<b>Date</b>	<b>Time</b>	<b>Reason for attending</b> Why did you visit your Optician?	<b>Report / Outcome</b> What happened? What issues were identified?



## Diary of Health Appointments

### Hospital Appointments

Consultant (Doctor) name:

Consultant address:

Consultant phone number:

<b>Date</b>	<b>Time</b>	<b>Reason for attending</b> Why did you visit the hospital?	<b>Report / Outcome</b> What happened? What issues were identified?



## Diary of Health Appointments

### Other Health Appointments

eg: Podiatry, Chiroprody, Hospital Specialist, Psychology, Psychiatry

Date	Time	Reason for attending Why did you visit?	Report / Outcome What happened? What issues were identified?

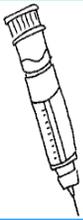


## Diary of Health Appointments

### Blood Pressure, Pulse, Weight

Write in each time you have your Blood pressure, pulse or weight measured.

Date	Blood Pressure	Pulse	Weight



## Diary of Health Appointments

### Other Health Checks

eg: Blood tests, Hearing test, Breast check, Cervical Smear, Prostrate Checks, Testicular Checks

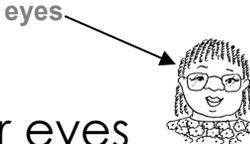
Date	Time	Reason for attending Why did you visit?	Report / Outcome What happened? What issues were identified?



## Health Action Plan

When writing your Health Action Plan think about all the information before this page and:

Your ears 

Your eyes 

Your feet 

Your teeth 

Going to the toilet 

The food you eat 

Epilepsy 

Diabetes 

Sexual Health 

Mental Health 

Your weight 



## Health Action Plan

**Name / describe the health issue :**

**To improve my health I want to achieve the following  
OUTCOMES / GOALS:**

1.

2.

3.

**To achieve my goals I will take the following  
ACTION**

**By When /  
How Often?**

1.

2.

3.

**To achieve my goals I will need the following  
SUPPORT**

**By Whom /  
How Often?**

1.

2.

3.

**In order to check my progress we will  
REVIEW**

**Location:**

**Date of Review:**



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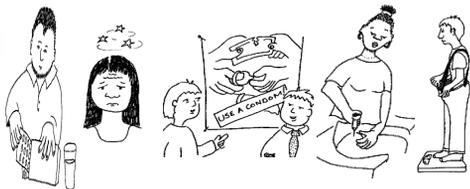
2.

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## SUMMARY: My Health Issues/ Long Term Conditions are:-

Name of the Condition e.g. Epilepsy, diabetes, Mental health, Sickle Cell Anaemia, Asthma	How does this effect me?	What is my number one Goal ?	What is the first action I have agreed to take?
1.			
2.			
3.			
4.			
5.			
6.			

**THIS PLAN WILL BE REVIEWED AT LEAST ANNUALLY**

**Location:**

Date of Review:

## Any Other Information