

Name: ..... Date: .....



## HEALTH MOT CHECKLIST

We have asked you to complete a Health MOT Checklist every time you have your PSA test done. This provides us with information to give you the best support to manage your condition. Please indicate which of the issues below apply to you, and if you would like a member of your clinical team to get in touch with you to discuss the issue.

### Physical concerns

	Yes	No	Discuss
Problems when urinating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Urine leakage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood in urine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bowel leakage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhoea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding from the bowel	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Getting / maintaining an erection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other sexual problem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bone pain (lasting more than 6 weeks)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pain in prostate region	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hot flushes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sore breasts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Poor Memory / concentration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling tired	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Poor appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nausea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Indigestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fevers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Poor sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling swollen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Unplanned weight loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Unplanned weight gain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other health issues (e.g. arthritis, smoking)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### Practical Concerns

	Yes	No	Discuss
Bathing or dressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Caring responsibilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Grocery shopping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Housing or finances	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Information needs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Laundry or housework	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Moving around	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Preparing food	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Transport or parking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Work or education	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
IT access / usage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### Emotional Concerns

	Yes	No	Discuss
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fears	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feeling nervous	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sadness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Worry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of interest in usual activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### Relationship Concerns

	Yes	No	Discuss
Relationship with children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Relationship with partner	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Relationship with others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sexual concerns	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### Care Plan

	Yes	No	Discuss
Do you need to update your care plan?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Notes: .....  
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