



# Bupa Advanced Health

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Please complete this questionnaire and bring it with you



# Your health assessment questionnaire

ID number

The Bupa Advanced Health Assessment has been designed to help you look after your health by providing a detailed picture of how healthy you are now, together with guidance on how to protect your health for the future. To do this we need to know a little more about you. This questionnaire gives us information about your health and health concerns.

**You should complete the blue sections** of this confidential questionnaire as fully as possible and bring it with you to your health assessment.

- If this is your **first** Bupa Advanced Health Assessment, please also complete the **pink section on page 8**.
- If you have been for a Bupa Advanced Health Assessment **before**, please use the **yellow sections** to indicate changes since your last visit.
- Please leave grey areas of the questionnaire for the doctor or health adviser to add their comments.

Don't worry if there are any questions you can't answer - these can be discussed during your assessment.

Please use BLOCK CAPITALS.

## Your details

Title	Mr <input type="checkbox"/>	Mrs <input type="checkbox"/>	Miss <input type="checkbox"/>	Ms <input type="checkbox"/>	Other (please indicate) <input type="text"/>
First name	<input type="text"/>				Surname <input type="text"/>
Date of birth	<input type="text"/> / <input type="text"/> / <input type="text"/>	Age <input type="text"/>	Previous name	<input type="text"/>	
Home address	<input type="text"/>				
	<input type="text"/>				Postcode <input type="text"/>
Home telephone number	<input type="text"/>		Work telephone number	<input type="text"/>	
Mobile telephone number	<input type="text"/>		Email	<input type="text"/>	
Are you covered by private medical insurance?	Bupa <input type="checkbox"/>	Membership number	<input type="text"/>	Other <input type="checkbox"/>	No <input type="checkbox"/>
Date questionnaire completed	<input type="text"/> / <input type="text"/> / <input type="text"/>				

Please complete the following if your employer is paying for this assessment:

Company name	<input type="text"/>				
Company address	<input type="text"/>				Postcode <input type="text"/>

## Keeping your GP informed

It is good practice for your GP to be kept informed of all aspects relating to your health. Please complete the information below if you are happy for us to send your GP an abbreviated version of your report and advise him or her of any abnormalities or significant results that may require follow-up investigation or treatment.

GP name	<input type="text"/>				
GP address	<input type="text"/>				Postcode <input type="text"/>
GP telephone number	<input type="text"/>				

## Monitoring further action

Bupa monitors what happens to customers after certain screening tests and certain abnormal results (eg cervical smears and mammography). This allows us to check on the quality of these tests and ensure that any necessary action has taken place. Please indicate whether or not you are happy for us to contact the following:

You	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Your GP	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Your specialist	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Please sign	<input type="text"/>				Date	<input type="text"/> / <input type="text"/> / <input type="text"/>		

This visit date	<input type="text"/>	Name of doctor	<input type="text"/>
First visit	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Name of health adviser <input type="text"/>
If no, date of last visit	<input type="text"/>		

## Information sheets

It is important to have read the information sheets to understand the tests we will carry out on you.

I confirm that I have received and read the following information sheets (please tick):

Important information for women about breast screening and mammography   
(for women aged 40 and over)

Important information for women about cervical smear screening   
(for women aged 20 and over)

Important information for men about PSA testing   
(for men aged 50 and over)

If you have any concerns about the information contained in these sheets, please ask your health assessment doctor.

Please sign

Date

 /  / 

## Please tell us your main reasons for attending

Review of health  Medical problem  Company requirement  Other reason

Do you have any specific areas of health interest or concern? Yes  No

Please outline below what you would like to get out of this health assessment

Your assessment includes a large number of tests covering a wide range of medical conditions. As with most medical tests and services it is not always possible to detect all diseases and abnormalities. If any medical symptoms you have do not resolve as expected or any new symptoms arise, you should seek further medical advice.

Clinical findings

## Your general health

Do you have any problems in any of the following areas that you would like to discuss with your Bupa doctor?

Please mark with a tick any areas for discussion and add any notes in the space provided.

Eyes	<input type="checkbox"/>
Ears, nose, throat	<input type="checkbox"/>
Mouth, teeth	<input type="checkbox"/>
Skin	<input type="checkbox"/>
Glands	<input type="checkbox"/>
Breathing	<input type="checkbox"/>
Cough, phlegm	<input type="checkbox"/>
Asthma	<input type="checkbox"/>
Bronchitis	<input type="checkbox"/>
Headaches	<input type="checkbox"/>
Sleep	<input type="checkbox"/>
Stress	<input type="checkbox"/>
Tiredness	<input type="checkbox"/>
Muscles	<input type="checkbox"/>
Joints	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>
Arm pain	<input type="checkbox"/>
Palpitations	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>
Poor circulation	<input type="checkbox"/>
Weight	<input type="checkbox"/>
Appetite, digestion	<input type="checkbox"/>
Difficulty swallowing	<input type="checkbox"/>
Abdominal pain	<input type="checkbox"/>
Change in bowel action	<input type="checkbox"/>
Blood or mucus in motions	<input type="checkbox"/>
Blood in urine	<input type="checkbox"/>
Pain passing urine	<input type="checkbox"/>
Incontinence, losing urine	<input type="checkbox"/>
Sexual matters or problems	<input type="checkbox"/>
Contraception	<input type="checkbox"/>
Sexually transmitted infection	<input type="checkbox"/>
Other	<input type="checkbox"/>

Clinical findings

# Please tell us about yourself and your family

Clinical findings

## Marital status

Has there been a change in your marital status since your last visit? Yes  No   
 If yes, please use the areas below to give details.

Are you:

Single  Married  Divorced  Separated  Widowed  Cohabiting  Other

If married, how long have you been married?  years

Spouse age and occupation

Health of spouse Good  Fair  Poor

Number of children Sons  Daughters

## Family history

Has there been a change in the health status of any members of your family since your last visit? Yes  No   
 If yes, please use the areas below to give details.

	Age if living	Age at death	State of health/Cause of death
Father	<input type="text"/>	<input type="text"/>	<input type="text"/>
Mother	<input type="text"/>	<input type="text"/>	<input type="text"/>
Brothers	<input type="text"/>	<input type="text"/>	<input type="text"/>
Sisters	<input type="text"/>	<input type="text"/>	<input type="text"/>
Sons	<input type="text"/>	<input type="text"/>	<input type="text"/>
Daughters	<input type="text"/>	<input type="text"/>	<input type="text"/>

Has any parent, grandparent, brother, sister, aunt or uncle suffered or died from any of the following? If yes, please give details and ages as appropriate.

	Yes	No	Details
Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Aortic aneurysm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Bowel cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Breast cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Ovarian cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Prostate cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>

## Family history *(continued)*

	Yes	No	Details
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	
Heart attack	<input type="checkbox"/>	<input type="checkbox"/>	
Angina or heart surgery	<input type="checkbox"/>	<input type="checkbox"/>	
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	
Mental illness	<input type="checkbox"/>	<input type="checkbox"/>	
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	
Skin cancer, malignant melanoma	<input type="checkbox"/>	<input type="checkbox"/>	
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	
Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>	

Any other comments or queries about family history

## Your job history

Are you currently working? Full-time  Part-time  Retired

*If yes, please give job title, department and company name*

*If yes, please give brief details of what your job entails*

Have you had a change of job, working conditions or job security since your last visit? Yes  No   
 If yes, please use the area below to give details.

Have you served in the armed forces? Yes  No

Have you ever worked in or visited the tropics? Yes  No

**If you are in employment please answer the following questions:**

How many years have you worked in your current employment?  years

How many hours a week on average do you work?  hours

How many hours a week on average do you work at home?  hours

How many nights on average each week are you away from home?  nights

How long does your journey to work take?  hours

How many business miles per year do you drive?  miles

Are you concerned about the security of your job? Yes  Partly  No

Do you take your full holiday allowance? Yes  Mostly  No

How many days off work due to sickness have you had in the past two years?  days

## Clinical findings

Indicate profession

Occupational codes

- 1 : Professional / senior management
- 2 : Middle management / technical / sales
- 3 : Clerical / administrative
- 4 : Manual
- 5 : Other occupations (inc. armed forces)
- 6 : Retired
- 7 : Permanently sick / disabled
- 8 : Home-maker
- 9 : Student
- 10: Not currently employed

## Your lifestyle

### Smoking

Do you smoke? Never  Given up  Yes

If given up, when? Year

If yes, how many per day? *Please specify cigarettes, cigars or pipe*

If you are a non-smoker, are you regularly exposed to a smoky atmosphere? Yes  No

### Alcohol

How often do you drink alcohol?

Never

On special occasions  Once or twice a month  Once or twice a week

Weekends only  Most days  Every day

How many units of alcohol do you typically drink over the course of a week?

*(A bottle of wine typically contains around nine units of alcohol, a pint of standard strength beer around 2.5 units and a pint of cider around three units. Spirits and fortified wines contain one unit of alcohol per pub measure)*

Have you recently felt that you should cut down on your drinking? Yes  No

Have people annoyed you by criticising your drinking? Yes  No

Have you ever felt bad or guilty about your drinking? Yes  No

Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover? Yes  No

Has drinking ever affected your driving or job? Yes  No

### Exercise and activity

How much aerobic exercise do you take?

*(By aerobic exercise we mean continuous bodily activity sufficient to increase your breathing rate moderately)*

20 minutes or more four or more times a week

20 minutes or more three times a week

20 minutes or more once or twice a week

Less than once a week

Are you a member of a gym? Yes  No

Are you generally active as part of your daily routine? Yes  No

*For instance, do you walk a lot, do you use the stairs instead of the lift, are you a keen gardener?*

Please give details of other activities such as gardening, DIY and household chores which make you breathe more heavily on a regular basis

### Clinical findings

Cigarettes

Mark box

1 = Never

2 = Ex

3 = Currently

No. of cigarettes per day

Alcohol

Mark box

x = None

1 = On special occasions

2 = Once or twice a month

3 = Once or twice a week

4 = Weekends only

5 = Most days

6 = Every day

Average units of alcohol per week

Exercise

Mark box

1 = Less than once a week

2 = 1-2 times a week

3 = 3 times a week

4 = 4 or more times a week

## Your lifestyle *(continued)*

### Your diet

How many portions of vegetables or salad (excluding potatoes) do you eat each day?

*If less than daily please specify*

How many portions of fruit including dried fruit and fruit juice do you eat each day?

*If less than daily please specify*

How many portions of carbohydrates like cereals, bread, pasta, rice and potatoes do you typically have each day?

*If less than daily please specify*

How often do you eat red meat, including beef, lamb and pork?

*Please specify eg daily, weekly etc*

How often do you eat processed meat including ham, bacon, salami, sausages etc?

*Please specify*

How often do you eat fish, excluding shellfish?

*Please specify*

How often do you eat cheese, cream, butter and yoghurt?

*Please specify*

How often do you eat chocolate and confectionery?

*Please specify*

How much cow's milk do you consume and is it full fat, semi-skimmed or skimmed?

*Please specify*

How often do you eat snack foods, including crisps and roasted nuts?

*Please specify*

How many cups of other fluids including water, fruit and herbal teas, fruit juice and fruit squashes and other soft drinks (excluding colas and sodas) do you typically drink each day?

How much caffeinated tea and coffee do you drink a day? Cups of tea  Cups of coffee

Has your weight been steady recently? Yes  No

Any other concerns or comments about your diet or weight?

## Clinical findings

## Your medical history

Yes No Details

Have you ever had a heart attack?			
Have you ever felt any pressure or heaviness in your chest?			
Have you ever had chest pain or any other heart problems?			
Have you ever noticed your heart beating abnormally?			
Have you ever had high blood pressure?			
Have you ever had a raised cholesterol level?			
Do you suffer from dizziness or fainting spells?			
Do your ankles ever swell?			
Do you suffer from leg pains after walking a short distance?			
Do you get out of breath easily?			

Have you had any major illnesses, operations or accidents since your last visit?

Yes  No

*If yes, please give details*

If this is your first Bupa health assessment, please complete this section.

Have you ever had any of the following? If yes, please give details and dates as appropriate.

Stroke			
Deep vein thrombosis			
Kidney problems, stones			
Cystitis (urine infection)			
Bronchitis, emphysema			
Asthma			
Tuberculosis			
Pneumonia, pleurisy			
Peptic ulcer, indigestion			
Jaundice, hepatitis			
Gallstones			
Piles or fissures			
Polyps in colon			
Colitis, irritable bowel			
Diabetes			
Thyroid problems			
Mumps			
Blood disorder eg anaemia			
Malaria			
Other tropical diseases			
Mental problems			
Depression			
Anxiety			
Fits, epilepsy, blackouts			
Migraine, recurrent headaches			
Concussion, head injury			
Cancer			
Other glandular disorders			
Problems with veins/varicose veins			
Glaucoma			
Ear disease or discharge			

Clinical findings

## Your medical history *(continued)*

	Yes	No	Details
Skin problems eg eczema			
Back problems			
Arthritis, gout			
Bone fractures, osteoporosis			
Muscle or nerve disease			
Sexually transmitted infection eg chlamydia			
Prostate or bladder problems			
Hernia operation			
Any other operations			
Accident, injuries			
Sterilisation, vasectomy			
Blood transfusion			

### In the past year, have you suffered from or been unable to work because of the following:

*(If yes, approximately how many days were you unable to work?)*

	Yes	No	No. of days not worked
a. Back pain	<input type="checkbox"/>	<input type="checkbox"/>	
b. Other muscle or joint pain	<input type="checkbox"/>	<input type="checkbox"/>	
c. Colds, influenza, virus infection	<input type="checkbox"/>	<input type="checkbox"/>	
d. Headaches	<input type="checkbox"/>	<input type="checkbox"/>	
e. Period pain, PMT	<input type="checkbox"/>	<input type="checkbox"/>	
f. Gastric upsets <i>(nausea, diarrhoea, vomiting)</i>	<input type="checkbox"/>	<input type="checkbox"/>	
g. Stress	<input type="checkbox"/>	<input type="checkbox"/>	
h. Other illness	<input type="checkbox"/>	<input type="checkbox"/>	
i. Injury	<input type="checkbox"/>	<input type="checkbox"/>	
j. Accidents	<input type="checkbox"/>	<input type="checkbox"/>	
k. Assault	<input type="checkbox"/>	<input type="checkbox"/>	

Please list any allergies *(including allergies to medicines)*

Please list any medicines you are taking, either prescribed or bought over the counter

Please give details of any hospital admissions in the past three years

Please give details of any tests or investigations you have had in the past three years

Clinical findings

## Your wellbeing

Please read this carefully. We would like to know how your health has been in general, over the past few weeks. Please answer ALL the questions by putting a tick (✓) in the box indicating the answer which you think most applies to you.

Have you recently:

been able to concentrate on whatever you're doing?	Better than usual <input type="checkbox"/>	Same as usual <input type="checkbox"/>	Worse than usual <input type="checkbox"/>	Much worse than usual <input type="checkbox"/>
lost much sleep over worry?	Not at all <input type="checkbox"/>	No more than usual <input type="checkbox"/>	Rather more than usual <input type="checkbox"/>	Much more than usual <input type="checkbox"/>
felt you were playing a useful part in things?	More so than usual <input type="checkbox"/>	Same as usual <input type="checkbox"/>	Less so than usual <input type="checkbox"/>	Much less than usual <input type="checkbox"/>
felt capable of making decisions about things?	More so than usual <input type="checkbox"/>	Same as usual <input type="checkbox"/>	Less so than usual <input type="checkbox"/>	Much less than usual <input type="checkbox"/>
felt constantly under strain?	Not at all <input type="checkbox"/>	No more than usual <input type="checkbox"/>	Rather more than usual <input type="checkbox"/>	Much more than usual <input type="checkbox"/>
felt you couldn't overcome your difficulties?	Not at all <input type="checkbox"/>	No more than usual <input type="checkbox"/>	Rather more than usual <input type="checkbox"/>	Much more than usual <input type="checkbox"/>
been able to enjoy your normal day-to-day activities?	More so than usual <input type="checkbox"/>	Same as usual <input type="checkbox"/>	Less so than usual <input type="checkbox"/>	Much less than usual <input type="checkbox"/>
been able to face up to your problems?	More so than usual <input type="checkbox"/>	Same as usual <input type="checkbox"/>	Less so than usual <input type="checkbox"/>	Much less than usual <input type="checkbox"/>
been feeling unhappy and depressed?	Not at all <input type="checkbox"/>	No more than usual <input type="checkbox"/>	Rather more than usual <input type="checkbox"/>	Much more than usual <input type="checkbox"/>
been losing confidence in yourself?	Not at all <input type="checkbox"/>	No more than usual <input type="checkbox"/>	Rather more than usual <input type="checkbox"/>	Much more than usual <input type="checkbox"/>
been thinking of yourself as a worthless person?	Not at all <input type="checkbox"/>	No more than usual <input type="checkbox"/>	Rather more than usual <input type="checkbox"/>	Much more than usual <input type="checkbox"/>
been feeling reasonably happy, all things considered?	More so than usual <input type="checkbox"/>	Same as usual <input type="checkbox"/>	Less so than usual <input type="checkbox"/>	Much less than usual <input type="checkbox"/>

## About your work

If you are in employment, for each question indicate the one answer that best describes your job or the way you deal with problems occurring at work. Please answer ALL the questions.

Do you have to work very fast?	Often <input type="checkbox"/>	Sometimes <input type="checkbox"/>	Seldom <input type="checkbox"/>	Never / almost never <input type="checkbox"/>
Do you have to work very intensively?	Often <input type="checkbox"/>	Sometimes <input type="checkbox"/>	Seldom <input type="checkbox"/>	Never / almost never <input type="checkbox"/>
Do you have enough time to do everything?	Often <input type="checkbox"/>	Sometimes <input type="checkbox"/>	Seldom <input type="checkbox"/>	Never / almost never <input type="checkbox"/>
Do you have the possibility of learning new things through your work?	Often <input type="checkbox"/>	Sometimes <input type="checkbox"/>	Seldom <input type="checkbox"/>	Never / almost never <input type="checkbox"/>
Does your work demand a high level of skill or expertise?	Often <input type="checkbox"/>	Sometimes <input type="checkbox"/>	Seldom <input type="checkbox"/>	Never / almost never <input type="checkbox"/>
Does your job require you to take the initiative?	Often <input type="checkbox"/>	Sometimes <input type="checkbox"/>	Seldom <input type="checkbox"/>	Never / almost never <input type="checkbox"/>
Do you have to do the same thing over and over again?	Often <input type="checkbox"/>	Sometimes <input type="checkbox"/>	Seldom <input type="checkbox"/>	Never / almost never <input type="checkbox"/>
Do you have a choice in deciding how you do your work?	Often <input type="checkbox"/>	Sometimes <input type="checkbox"/>	Seldom <input type="checkbox"/>	Never / almost never <input type="checkbox"/>
Do you have a good deal of say in decisions about work?	Often <input type="checkbox"/>	Sometimes <input type="checkbox"/>	Seldom <input type="checkbox"/>	Never / almost never <input type="checkbox"/>
Do you find your job satisfying and fulfilling?	Yes <input type="checkbox"/>		No <input type="checkbox"/>	

## Clinical findings

## Health questions for men

Do you regularly examine your testes? Yes  No

Have you ever noticed any lumps or swellings in your testes? Yes  No

Do you get up at night to pass urine on a regular basis? Yes  No

*If yes, how many times a night?*

Have you noticed any change in the flow rate or stream of your urine? Yes  No

Do you have difficulty in starting and stopping passing urine? Yes  No

Do you have any problems with sexual function? Yes  No

## Health questions for women

### Cervical smears

If you have a cervical smear the results will be sent to the Health Authority or Health Board to ensure continuity of long-term follow-up of any abnormality. This will not affect your routine NHS recall.

When was your last cervical smear? Date  /  /

What was the result?

Have you ever had an abnormal smear? Yes  No

*If yes, please give age and details*

Do you have any concerns about your breasts? Yes  No

*If yes, please give details*

Have you ever had a mammogram? Yes  No

*If yes, when and where was your last one performed and what was the result?*

Have you ever had a breast problem or needed breast surgery? Yes  No

*If yes, please give details*

Are you breast aware and do you know how to examine your breasts? Yes  No

Has any member of your family had cancer of the breast, ovary or any other gynaecological cancer? Yes  No

*If yes, please give age and details*

## Clinical findings

## Health questions for women *(continued)*

Is breast tenderness a problem?

Yes  No

*If yes, please give details*

When was your last period?

Date  /  /

Have your recent periods been regular?

Yes  No

Do you have any problems with your periods?

Yes  No

Are pre-menstrual symptoms a problem?

Yes  No

Are you sexually active?

Yes  No

Do you have any sexual problems?

Yes  No

Are you using contraception?

Yes  No

Is vaginal discharge a problem?

Yes  No

Do you have any bleeding between periods or after intercourse?

Yes  No

Have you ever undergone any gynaecological treatment or operations? Yes  No

*If yes, please give age and details*

Have you had your menopause? Yes  No  If yes, at what age?

Do you have menopausal symptoms, eg hot flushes, night sweats? Yes  No

Are you taking hormone replacement therapy (HRT)? Yes  No

*If yes, please give name of product*

Would you like to discuss HRT? Yes  No

Have you ever been treated for infertility? Yes  No

Have you ever been pregnant? Yes  No

*If yes, please give details*

Were the pregnancies and deliveries normal? Yes  No

Would you like to discuss pre-conceptual care? Yes  No

**Thank you for completing this questionnaire.**  
The remaining pages are for your Bupa doctor to complete.

## Clinical findings

Parity:  +

Age FFTP \_\_\_\_\_

Details

## Consent and previous visits

### Physical examinations

If you will be undertaking a full examination please ensure you have the customer's agreement to this.

Physical examination has been discussed with the customer and permission obtained    Yes        No   

### Chaperone

A chaperone has been offered during the physical examination    Yes        No   

A chaperone has been requested during this examination    Yes        No   

by    Doctor        Customer   

If yes, then record the name of the chaperone in the box below

Key results from previous visit (Please record items from previous visit if applicable)

Previous visit date:	Previous abnormalities
Blood pressure:	
Weight:	
BMI:	
Body fat percentage:	Previous action points
PSA TSH:	
Activity level:	
Total cholesterol:	
HDL cholesterol:	

# Clinical findings

NORMAL  
ABNORMAL

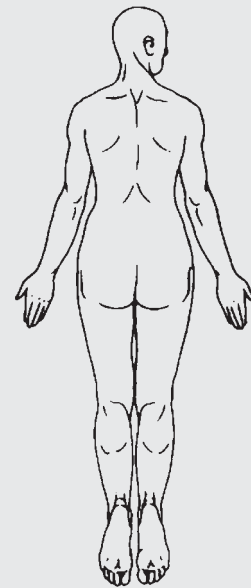
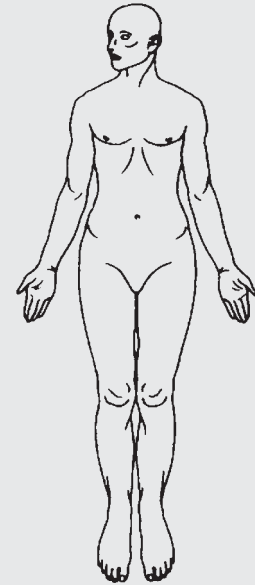
	NORMAL	ABNORMAL
Eyes/fundi		
Ears and nose		
Teeth and gums		
Mouth and throat		
Skin		
Lymph glands		
Central NS		
Peripheral NS		
Heart size		
Heart rhythm		
Heart sounds		
Carotid sounds		
Peripheral arteries		
Veins		
Upper resp. tract		
Lungs		
Abdominal palpation		
Abdominal organs		
Liver		
Hernial orifices		
Rectum (40 plus)		
Prostate		
Male genitalia		
Axial skeleton (posture)		
Upper limbs (muscles/joints)		
Lower limbs (muscles/joints)		

Build/shape:

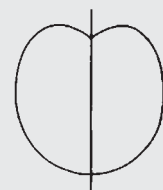
Pulse/rhythm:

BP:

Mood and rapport:



PROSTATE:



PSA Test: Done  Not done

PSA counselling Yes  No

Reasons:

# Clinical findings

**Audiology:**

**Additional tests:**

**Significant test results/trends:**

**Action plan:**

*(including advice literature given)*

Please check you have fulfilled  
the customer's needs on page 2

**Comments for GP:**

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**Coronary risk factors**

**Framingham score**

Take points from score sheet

Sex	Select correct score sheet by sex	
Age		
Total cholesterol		
HDL cholesterol		
Blood pressure		
Diabetes		
Cigarette smoking		
<b>Point total</b>		
CHD risk		
Comparative risk		

**Report**

To pt. <input type="checkbox"/>	GP <input type="checkbox"/>	Co MO <input type="checkbox"/>
Co. lay <input type="checkbox"/>	Other <input type="checkbox"/>	<input type="checkbox"/>

Doctor's signature \_\_\_\_\_

Date \_\_\_\_\_

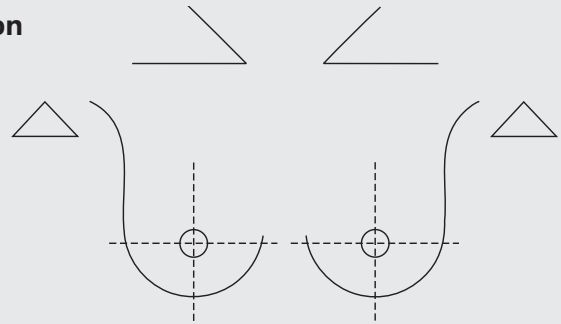
Health adviser's signature \_\_\_\_\_

Date \_\_\_\_\_

# Clinical findings - Women's section

Past breast history:

Clinical examination



Present symptoms:

Hormones Yes  No

**Clinical examination:**

(If abnormal please give details and mark asymmetry, scars, skin lesions, lumps, tenderness, etc. on diagram)

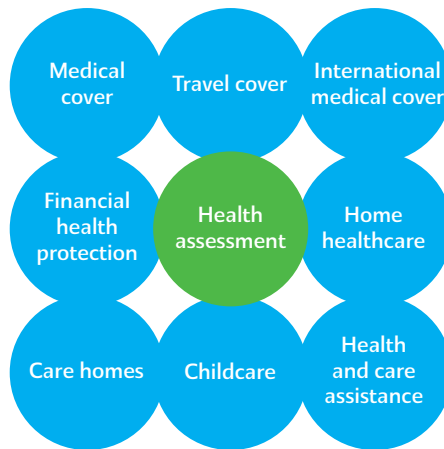
Clinical summary:	Right	Left		Right	Left
Normal	<input type="checkbox"/>	<input type="checkbox"/>	Nipple normal	<input type="checkbox"/>	<input type="checkbox"/>
Benign abnorm.	<input type="checkbox"/>	<input type="checkbox"/>	Nipple inverted	<input type="checkbox"/>	<input type="checkbox"/>
Suspicious abnorm.	<input type="checkbox"/>	<input type="checkbox"/>	Nipple discharge	<input type="checkbox"/>	<input type="checkbox"/>
Mammography	Yes <input type="checkbox"/>	No <input type="checkbox"/>			

Reason:

Recommendation: Screening review  Referral  Clinical re-check  Mamm re-check

## GYNAECOLOGICAL symptoms and assessment

<b>Clinical</b>						
<b>Abdomen:</b>	Normal <input type="checkbox"/>	Abnormal <input type="checkbox"/>	<b>Vulva:</b>	Normal <input type="checkbox"/>	Abnormal <input type="checkbox"/>	
<b>Vagina:</b>	Normal <input type="checkbox"/>	Atrophic <input type="checkbox"/>	Intacta <input type="checkbox"/>	Prolapse <input type="checkbox"/>	Discharge <input type="checkbox"/>	
<b>Cervix:</b>	Normal <input type="checkbox"/>	Atrophic <input type="checkbox"/>	Cont. Bld <input type="checkbox"/>	Absent <input type="checkbox"/>	Polyp <input type="checkbox"/>	Nab foll. <input type="checkbox"/>
	Ectopia <input type="checkbox"/>	Suspicious <input type="checkbox"/>		Cervix fully visualised <input type="checkbox"/>		360° sweep taken <input type="checkbox"/>
<b>Uterus:</b>	Normal <input type="checkbox"/>	Abnormal <input type="checkbox"/>	Absent <input type="checkbox"/>	Mobile <input type="checkbox"/>	Fixed <input type="checkbox"/>	
<b>Position:</b>	A/V <input type="checkbox"/>	R/V <input type="checkbox"/>	Axial <input type="checkbox"/>			
<b>Adnexae:</b>	Normal <input type="checkbox"/>	Abnormal <input type="checkbox"/>				
<b>Cx. Smear:</b>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Vault <input type="checkbox"/>			
<b>HVS:</b>	Yes <input type="checkbox"/>	No <input type="checkbox"/>				
<b>HPV test:</b>	Yes <input type="checkbox"/>	No <input type="checkbox"/>				
<b>HPV Counselling:</b>	Yes <input type="checkbox"/>	No <input type="checkbox"/>				



## The world of Bupa

**Call 0800 12 34 56**

**for information on Bupa Wellness**

Lines open 8am - 8pm weekdays.

Calls will be recorded and may be monitored.

[www.bupa.co.uk/wellness](http://www.bupa.co.uk/wellness)

**Bupa Wellness offers you:**

- Health assessments
- Occupational health
- Stress management
- Dental services
- Musculoskeletal services
- Private GP services

**Call 0800 00 10 10**

**for information on all other Bupa services**

Lines open 24 hours.

Calls will be recorded and may be monitored.

[www.bupa.com](http://www.bupa.com)

