



Bupa Advanced Health

Please complete this questionnaire and bring it with you



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

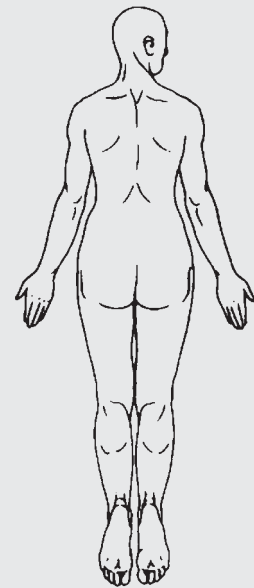
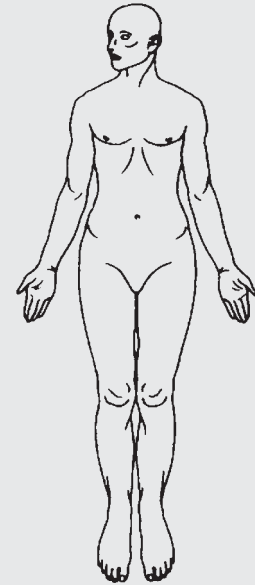
	NORMAL	ABNORMAL
Eyes/fundi		
Ears and nose		
Teeth and gums		
Mouth and throat		
Skin		
Lymph glands		
Central NS		
Peripheral NS		
Heart size		
Heart rhythm		
Heart sounds		
Carotid sounds		
Peripheral arteries		
Veins		
Upper resp. tract		
Lungs		
Abdominal palpation		
Abdominal organs		
Liver		
Hernial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

Build/shape:

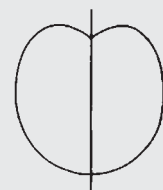
Pulse/rhythm:

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:

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		
Point total		
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 _____

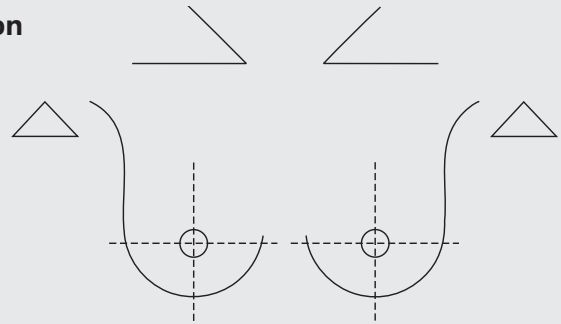
Health adviser's signature _____

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)

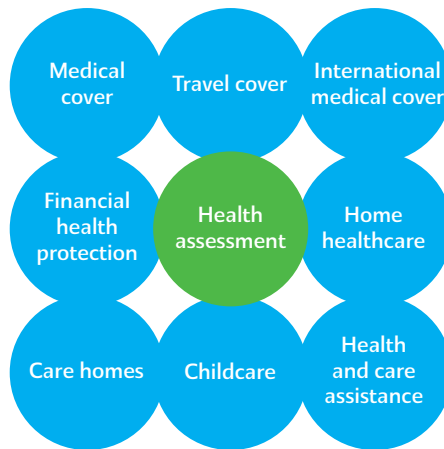
Clinical summary:	Right	Left		Right	Left
Normal	<input type="checkbox"/>	<input type="checkbox"/>	Nipple normal	<input type="checkbox"/>	<input type="checkbox"/>
Benign abnorm.	<input type="checkbox"/>	<input type="checkbox"/>	Nipple inverted	<input type="checkbox"/>	<input type="checkbox"/>
Suspicious 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

Clinical						
Abdomen:	Normal <input type="checkbox"/>	Abnormal <input type="checkbox"/>	Vulva:	Normal <input type="checkbox"/>	Abnormal <input type="checkbox"/>	
Vagina:	Normal <input type="checkbox"/>	Atrophic <input type="checkbox"/>	Intacta <input type="checkbox"/>	Prolapse <input type="checkbox"/>	Discharge <input type="checkbox"/>	
Cervix:	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"/>
Uterus:	Normal <input type="checkbox"/>	Abnormal <input type="checkbox"/>	Absent <input type="checkbox"/>	Mobile <input type="checkbox"/>	Fixed <input type="checkbox"/>	
Position:	A/V <input type="checkbox"/>	R/V <input type="checkbox"/>	Axial <input type="checkbox"/>			
Adnexae:	Normal <input type="checkbox"/>	Abnormal <input type="checkbox"/>				
Cx. Smear:	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Vault <input type="checkbox"/>			
HVS:	Yes <input type="checkbox"/>	No <input type="checkbox"/>				
HPV test:	Yes <input type="checkbox"/>	No <input type="checkbox"/>				
HPV Counselling:	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

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

