



Bupa Allergy Health

Please complete this questionnaire and bring it with you



Your health check questionnaire

ID number

The Bupa Allergy check has been designed to try and find out what causes your symptoms. 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 appointment.

- 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 visit.

Please use BLOCK CAPITALS.

Your details

Title Mr Mrs Miss Ms Other (please indicate)

First name Surname

Date of birth / / Age

Home address
 Postcode

Home telephone number Work telephone number

Mobile telephone number Email

Are you covered by private medical insurance? Bupa Membership number Other No

Date questionnaire completed / /

If your company is paying for this health check they will be aware of your attendance, please tick to confirm that you are aware of this.

(please tick):

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 results to your GP and advise him or her of any abnormalities or significant results that may require follow-up investigation or treatment.

GP name

GP address
 Postcode

GP telephone number

Monitoring further action

Bupa monitors what happens to customers after certain tests and certain abnormal results. 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 No Your GP Yes No Your specialist Yes No

Please sign Date / /

This visit date Name of doctor

First visit Yes No Name of health adviser

If no, date of last visit

Please tell us your reason for attending

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.

Family history

Asthma	<input type="checkbox"/>	Who:	<input type="text"/>
Eczema	<input type="checkbox"/>	Who:	<input type="text"/>
Seasonal/year round allergies	<input type="checkbox"/>	Who:	<input type="text"/>
Other allergies (drugs, bee sting, food etc)	<input type="checkbox"/>	Who:	<input type="text"/>
Sinus problems	<input type="checkbox"/>	Who:	<input type="text"/>

Your lifestyle

Smoking

Do you smoke? No Given up Yes

Your diet

List any food allergies or reactions experienced

Your symptoms

When did your symptoms begin?

Are your symptoms getting worse? Yes No

Please mark with a tick if you experience any of the following

Cough	<input type="checkbox"/>	Itchy/watery eyes	<input type="checkbox"/>	Eczema	<input type="checkbox"/>
Wheezing	<input type="checkbox"/>	Postnasal drip	<input type="checkbox"/>	Hives/Swelling	<input type="checkbox"/>
Shortness of breath	<input type="checkbox"/>	Phlegm/sputum	<input type="checkbox"/>	Headaches	<input type="checkbox"/>
Chest tightness	<input type="checkbox"/>	Nasal polyps	<input type="checkbox"/>	Snoring	<input type="checkbox"/>
Sneezing	<input type="checkbox"/>	Poor sense of smell	<input type="checkbox"/>	Fatigue	<input type="checkbox"/>
Runny nose	<input type="checkbox"/>	Ear infections	<input type="checkbox"/>	Other	<input type="checkbox"/>
Nasal congestion	<input type="checkbox"/>	Sinus infections	<input type="checkbox"/>	Details	<input type="text"/>
Itchy nose	<input type="checkbox"/>	Blocked ears	<input type="checkbox"/>		<input type="text"/>

Clinical findings

Your symptoms *(continued)*

Please mark with a tick if any of the following seem to trigger your symptoms

Grass	<input type="checkbox"/>	Cosmetics	<input type="checkbox"/>	Nervousness	<input type="checkbox"/>
Hay	<input type="checkbox"/>	Aerosol sprays	<input type="checkbox"/>	Cold air	<input type="checkbox"/>
Mould and mildew	<input type="checkbox"/>	Perfumes	<input type="checkbox"/>	Humidity	<input type="checkbox"/>
Basements	<input type="checkbox"/>	Insecticides	<input type="checkbox"/>	Weather changes	<input type="checkbox"/>
Leaves	<input type="checkbox"/>	Odors	<input type="checkbox"/>	Latex	<input type="checkbox"/>
Cats	<input type="checkbox"/>	Drafts	<input type="checkbox"/>	Other	<input type="checkbox"/>
Dogs	<input type="checkbox"/>	House dust	<input type="checkbox"/>	Details	
Horses	<input type="checkbox"/>	Smoke	<input type="checkbox"/>		
Other animals	<input type="checkbox"/>	Pollution	<input type="checkbox"/>		
Alcoholic beverages	<input type="checkbox"/>	Exercise	<input type="checkbox"/>		

When are your symptoms worse?

Year round	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Summer	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Spring	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Autumn	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Winter	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>

Are your symptoms better away from home? Yes No

Are your symptoms better away from work? Yes No

Is there anything at work which you think triggers your symptoms? Yes No

Details

Have you been skin tested? Yes No

Results

Have you had allergy injections? Yes No When:

Have you received cortisone (prednisone, methylprednisolone, etc.) drugs? Yes No

When How much

Occupation (current or former)

Clinical findings

Your past medical history

Check all that apply to you

- | | | | |
|-------------------------|--------------------------|------------------|--------------------------|
| Diabetes | <input type="checkbox"/> | Thyroid disease | <input type="checkbox"/> |
| Cancer | <input type="checkbox"/> | Arthritis | <input type="checkbox"/> |
| High blood pressure | <input type="checkbox"/> | Hay fever | <input type="checkbox"/> |
| Anaemia/blood disorder | <input type="checkbox"/> | Diarrhoea | <input type="checkbox"/> |
| Kidney/bladder disease | <input type="checkbox"/> | Cataracts | <input type="checkbox"/> |
| Back problems | <input type="checkbox"/> | Heartburn/reflux | <input type="checkbox"/> |
| Liver disease/hepatitis | <input type="checkbox"/> | Seizures | <input type="checkbox"/> |
| Heart problems/murmur | <input type="checkbox"/> | Migraines | <input type="checkbox"/> |
| Osteoporosis | <input type="checkbox"/> | Depression | <input type="checkbox"/> |
| Asthma | <input type="checkbox"/> | Anxiety | <input type="checkbox"/> |
| Gynaecological problems | <input type="checkbox"/> | Loss of hearing | <input type="checkbox"/> |
| Glaucoma | <input type="checkbox"/> | Emphysema | <input type="checkbox"/> |
| Peptic ulcer | <input type="checkbox"/> | | |

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

Please give details of **any drug allergies** that you have experienced

Please give details of **any reactions to insect bites** that you have experienced

Clinical findings

Clinical findings

Additional tests:

Significant test results/trends:

Action plan:

(including advice literature given)

Comments for GP:

Doctor's signature _____

Date _____

