



# Bupa Core Health Check

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Please complete this questionnaire and bring it with you





## Please tell us your main reasons for attending

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

Your health check includes a number of tests designed to help you understand your current health status and how your lifestyle affects your future health risks. 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.

## Your general health

Do you have any concerns about your lifestyle and its impact on your future health?

## Please tell us about yourself and your family

**Marital status** Are you:

Single  Married/Civil Partnership  Divorced/Dissolved Civil Partnership  Separated

Widowed/Surviving Civil Partnership  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

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

	Yes	No	Details
Heart disease - including high blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	

Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	
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Clinical findings

## 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)*

### 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?*

### Your diet

Do you limit the amount of refined sugar in your diet? Yes  No

*eg sugar, sweets, biscuits, chocolate, cakes*

Do you eat foods high in fibre on a daily basis? Yes  No

*eg wholemeal bread, pulses and lentils, high fibre breakfast cereals, and generally unrefined wholemeal foods such as brown rice and brown pasta*

Do you limit your intake of saturated fat? Yes  No

*eg butter, cream, cakes, eggs and fatty meats*

Do you eat five or more portions of fruit and/or vegetables each day? Yes  No

Do you eat more fish and poultry than red meat? Yes  No

Do you drink eight or more cups or glasses of fluid per day? Yes  No

*eg water, soft drinks and non-caffeinated tea or coffee*

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

### 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 medical history

Have you ever had any condition that has needed treatment from your doctor that affected:

Your heart, including blood pressure?

Yes  No

Do you have diabetes?

Yes  No

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"/>	<input type="text"/>
b. Other muscle or joint pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
c. Colds, influenza, virus infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
d. Period pain, PMT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
e. Gastric upsets (nausea, diarrhoea, vomiting)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
f. Stress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
g. Other illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
h. Injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
i. Accidents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
j. Assault	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>

Clinical findings

## Health question for men

Do you regularly examine your testes?

Yes  No

## Health question for women

Are you breast aware and do you know how to examine your breasts?

Yes  No

## 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"/>

## Clinical findings

## 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"/>	

**Thank you for completing this questionnaire.**

The remaining pages are for your Bupa health adviser to complete.

# Clinical test sheet

<b>CUSTOMER LABEL</b>	Age	<b>Core Health Check</b>	Health Adviser
	Male / Female		Test commenced
	First / repeat		
	Fasted / non- fasted		Test Room

<b>Lifestyle information</b>	(1) Sedentary	(2) Occasional	(3) Formal
Exercise rating (1-11)	Type:		
Non smoker / Ex- smoker / Smoker	No Per day:	Cigar / Pipe	
Alcohol      Never / Occasional / Regular	Units per week		

Height	cm /	Ft	in	Weight	kg	st	lbs	Notes
Body fat			%	Weight range	-	kg	st	lbs - st lbs
Acceptable range			%	Lean weight	kg	Waist	cm	Waist/Ht % BMI

Blood pressure (1)	/	Pulse	Blood pressure (2)	/	Pulse
Venepuncture by:					
Notes / Obs:					

<b>Coronary risk factors</b>	
<b>Framingham score</b>	
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	

<b>Diabetes risk score</b>	
Take points from score sheet	
Age	
BMI	
Waist circumference	
Exercise	
Fruit & veg	
BP medication	
High blood glucose	
Family history	
<b>Point total</b>	
Diabetes Risk Score	

**Clinical notes:**

**Action plan:**

*(including advice literature given)*

**GP - Key health results:**

Any actions?

**Report:**

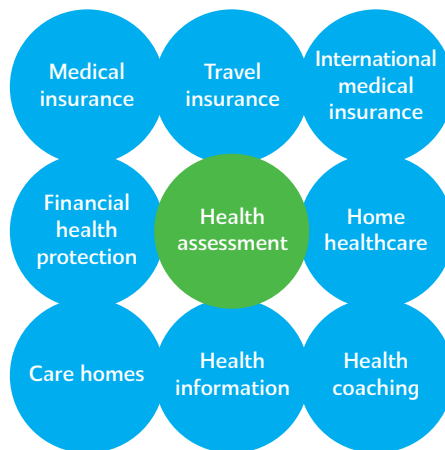
To customer

GP

Company

Health Adviser signature \_\_\_\_\_

Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_



## The world of Bupa

**Call 0800 616 029**

**for information on Bupa health assessments**  
 Lines open 8am - 8pm weekdays, 8am - 1pm Saturday.  
 Calls will be recorded and may be monitored.  
[www.bupa.co.uk/wellness](http://www.bupa.co.uk/wellness)

**Bupa 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)

