



Bupa Coronary Health

Please complete this questionnaire and bring it with you

If you have purchased this product in addition to one of the core health assessments you do not need to complete the personal information section. Please only complete the additional questions specific to this health check.



Your health check questionnaire

ID number

The Bupa Coronary Health Check has been designed to look for the early signs of heart disease. 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 appointment.

Please use BLOCK CAPITALS.

Your details

Title Mr Mrs Miss Ms Other (please indicate)

First name Surname

Date of birth / / Age Previous name

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 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 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

Information sheets

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

I confirm that I have received and read the coronary health information sheet

(please tick):

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

Please sign

Date

 / /

Please tell us your reason for attending

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.

This influences the risk of heart disease

Caucasian Afro-Caribbean Asian Chinese

Other (please specify)

Family history

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

	Yes	No	Details
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	

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*

Alcohol

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)

What type of alcohol do you normally drink (spirits, wine, beer etc)

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

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

Are you a vegetarian or vegan? Yes No

Clinical findings

Your lifestyle

Your diet

How often do you eat cheese, cream and butter?

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

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

Stroke

Diabetes

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

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

Clinical findings

Consent

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

Clinical findings

	NORMAL	ABNORMAL	
Heart size			
Heart rhythm			
Heart sounds			
Carotid sounds			
Peripheral arteries			

Build/shape:

Pulse/rhythm:

BP:

Clinical findings

Additional tests:

Significant test results/trends:

Action plan:

(including advice literature given)

Comments for GP:

Coronary risk factors

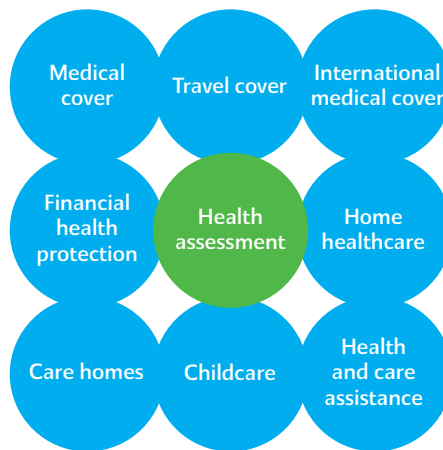
Framingham score

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		

Doctor's signature _____

Date _____



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for information on Bupa Wellness

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Calls will be recorded and may be monitored.
www.bupa.co.uk/wellness

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