

Bupa Essential Health

Please complete this questionnaire and bring it with you



Your health assessment questionnaire

ID number

The Bupa Essential Health Assessment has been designed to help you look after your health by focusing on key health issues 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.

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

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"/>				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. 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	<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"/>		

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.

Your general health

Do you have any medical concerns you would like to discuss with your Bupa doctor?

Please tell us about yourself and your family

Marital status 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

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
Heart disease - including high blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Bowel problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Mental problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Any form of cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>

Your job history

Are you currently working? Full-time Part-time Retired No

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

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

If you are in employment please answer the following questions:

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

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

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)

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

Your lungs - for instance pneumonia, asthma, bronchitis? Yes No

Your abdomen - for instance peptic ulcer, hiatus hernia, irritable bowel syndrome? Yes No

Your kidneys or bladder - for instance kidney stones, urinary infection or cystitis? Yes No

Also:

Have you ever had a fit or fainted? Yes No

Have you ever had a stroke or 'mini-stroke'? Yes No

Have you ever had or do you have diabetes or any other endocrine (glandular) problems? Yes No

Have you ever had any periods of anxiety or depression that have interfered with the way you lead your life? Yes No

Have you ever had any form of cancer? Yes No

If you are a woman, have you had any breast or gynaecological problems? 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. Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
e. Period pain, PMT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
f. Gastric upsets (nausea, diarrhoea, vomiting)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
g. Stress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
h. Other illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
i. Injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
j. Accidents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
k. Assault	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>

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"/>

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"/>	

Health questions for men

Have you had any problems with your prostate? Yes No

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

If yes, how many times a night?

Do you examine your testes? Yes No

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

Health questions for women

Do you have any concerns about your breasts? Yes No

Have you ever had a mammogram? Yes No

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

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

When was your last period? Date / /

When was your last cervical smear? Date / /

What was the result?

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

Do you have any sexual problems? Yes No

Do you have any bleeding between periods or after intercourse? Yes No

Would you like to discuss hormone replacement therapy? Yes No

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

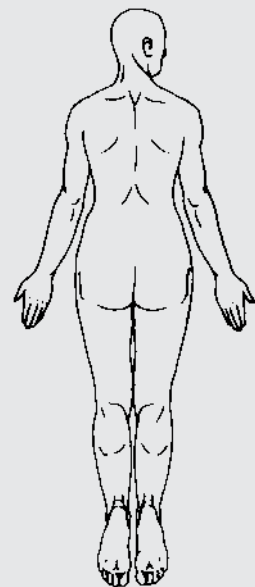
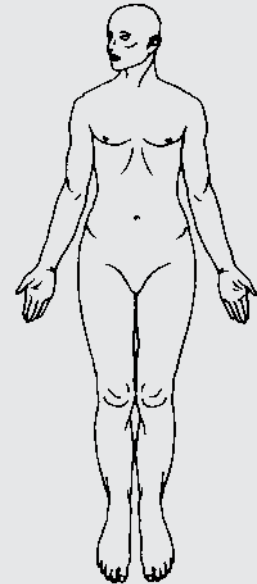
	NORMAL	ABNORMAL
Eyes/fundi		
Ears and nose		
Teeth and gums		
Mouth and throat		
Skin		
Lymph glands		
Central NS		
Peripheral NS		
Heart size		
Heart rhythm		
Heart sounds		
Carotid sounds		
Peripheral arteries		
Veins		
Upper resp. tract		
Lungs		
Abdominal palpation		
Abdominal organs		
Liver		
Hernial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

Build/shape:

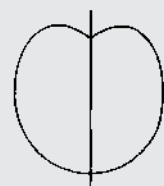
Pulse/rhythm:

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"/>	

Doctor's signature _____

Date _____

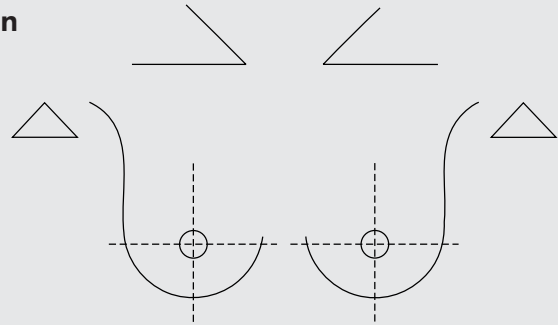
Health adviser's signature _____

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)

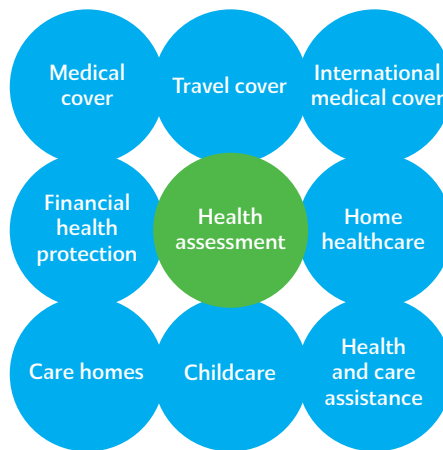
Clinical summary:	Right	Left		Right	Left
Normal	<input type="checkbox"/>	<input type="checkbox"/>	Nipple normal	<input type="checkbox"/>	<input type="checkbox"/>
Benign abnorm.	<input type="checkbox"/>	<input type="checkbox"/>	Nipple inverted	<input type="checkbox"/>	<input type="checkbox"/>
Suspicious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

Notes

Notes



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

