



Bupa Female Health

Please complete this questionnaire and bring it with you



Your health assessment questionnaire

ID number

The Bupa Female Health Assessment has been designed to help you look after your health by providing a detailed picture of your gynaecological and breast health, together 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.

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

- If you have been for a Bupa Female Health Assessment **before**, please use the **yellow sections** to indicate changes since your last visit.
- Please leave grey areas of the questionnaire for the wellwoman sister or doctor 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 | 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"/> | / | Age <input type="text"/> | Surname at birth | <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"/> | / | | | |

Please complete the following if your employer is paying for this assessment:

| | | | | | | |
|-----------------|----------------------|--|--|--|----------|----------------------|
| Company name | <input type="text"/> | | | | | |
| Company address | <input type="text"/> | | | | | |
| | <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"/> | | | | | |
| | <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 (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 <input type="checkbox"/> | No <input type="checkbox"/> | Your GP | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Your specialist | Yes <input type="checkbox"/> | No <input type="checkbox"/> | | | |
| Please sign | <input type="text"/> | | | | | Date | <input type="text"/> | / | <input type="text"/> | / | <input type="text"/> |

| | | | | |
|---------------------------|------------------------------|-----------------------------|------------------------|----------------------|
| 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"/> | | | |

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)

If you have any concerns about the information contained in these sheets, please ask your wellwoman sister or 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 number of tests covering a 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.

Please tell us about yourself and your family

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/Civil Partnership Divorced/Dissolved Civil Partnership Separated

Widowed/Surviving Civil Partnership Cohabiting Other

Age and occupation of partner

Health of partner

Good

Fair

Poor

Number of children

Sons

Daughters

Family history

Has there been a change in the health status of any members of your

Yes

No

family since your last visit? 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"/> |

For clinicians notes

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

Your lifestyle

Smoking

Do you smoke cigarettes? Never Given up Yes

If yes, how many per day?

If you are a non-smoker, are you regularly exposed to a smoky atmosphere? Yes No

Do you smoke pipes or cigars? Never Given up Yes

If yes, how much

If given up, how many years ago? Year

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)

Less than once a week
20 minutes or more once or twice a week
20 minutes or more three times a week
20 minutes or more four or more times 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?

For clinicians notes

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

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

Do you limit the amount of refined sugar in your diet?

eg sugar, sweets, biscuits, chocolate, cakes

Yes No

Do you eat foods high in fibre on a daily basis?

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

Yes No

Do you limit your intake of saturated fat?

eg butter, cream, cakes and fatty meats

Yes No

Do you eat five or more portions of fruit and/or vegetables each day?

eg 1 apple, banana, pear, or other similar sized fruit, 2 plums or similar sized fruit, 3 heaped tablespoons of vegetables, 3 heaped tablespoons of beans and pulses, 1 heaped tablespoon of dried fruit, a dessert bowl of salad or a glass (150ml) of fruit juice

Yes No

Do you eat more fish and poultry than red meat?

Yes No

How much fluid do you drink each day? (excluding alcohol)

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

How much caffeinated fluid do you drink a day?

eg tea, coffee, caffeinated soft drinks

Has your weight been steady recently?

Yes No

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

Have you ever had any breast or gynaecological problems?

Yes No

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

For clinicians notes

Health questions

Breast Health

Are you breast aware and do you know how to examine your breasts? Yes No

Is breast tenderness a problem? 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 age and details

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

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

For clinicians notes

Health questions *(continued)*

When was your last period?

Date / /

Have your recent periods been regular?

Yes No

Do you have any bleeding between periods or after intercourse?

Yes No

Do you have any problems with your periods?

Yes No

Is vaginal discharge a problem?

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

Have you ever undergone any gynaecological treatment or operations? Yes No

If yes, please give age and details if not already mentioned

Would you like to discuss pre-conceptual care?

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

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

Thank you for completing this questionnaire.
The remaining pages are for your wellwoman sister or doctor to complete.

For clinicians notes

Parity: ^G + ^P

Age FFTP _____

Details

Consent and previous visits

Physical examinations

If you will be undertaking an 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 wellwoman sister/doctor Customer

If yes, then record the name of the chaperone in the box below

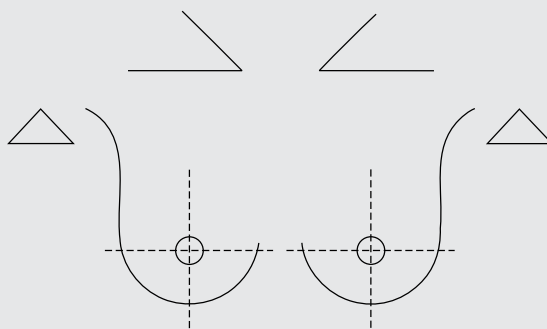
Key results from previous visit (Please record items from previous visit if applicable)

| | |
|----------------------|------------------------|
| Previous visit date: | Previous abnormalities |
| Blood pressure: | |
| Weight: | |
| BMI: | |
| Total cholesterol: | Previous action points |
| HDL Cholesterol: | |

Clinical findings

Past breast history:

Clinical examination



Present symptoms:

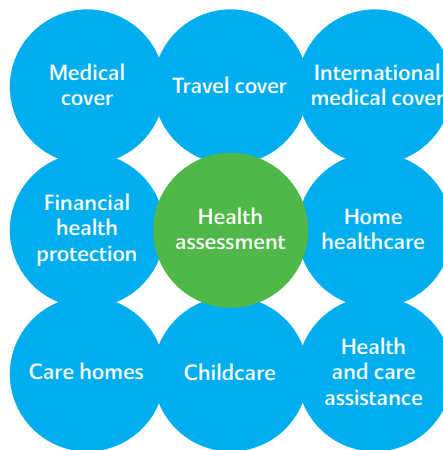
HRT/Oral Contraception

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: _____ | | |

Further assessment indicated clinically Yes No



The world of Bupa

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for information on Bupa Wellness

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Calls will be recorded and may be monitored.
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