



# Bupa Forward Planning

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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 Forward Planning check has been designed to help you find out how many eggs you have left in your ovary.

**You should complete the blue sections** of this confidential questionnaire as fully as possible and bring it with you to your 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	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"/>			
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"/>					

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):

## 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 Forward Planning information sheet (please tick):

If you have any concerns about the information contained in this sheet, please ask the doctor.

Please sign

Date

## Family history

Do you have a family history of early ovarian failure?

Yes  No

If yes, please use the area below to give details.

This visit date

Name of doctor

First visit

Yes  No

Name of health adviser

If no, date of last visit

## Your medical history

Please list any medicines you are taking, either prescribed or bought over the counter

If you have been taking oral contraception, how long has it been since you stopped?

Please give details of any tests or investigations you have had in the past three years

When was your last period?

Date  /  /

Have your periods been regular?

Yes  No

Do you have any problems with your periods?

Yes  No

*If yes, please give details*

Are pre-menstrual symptoms a problem?

Yes  No

*If yes, please give details*

Are you using contraception?

Yes  No

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

*If yes, please give details*

At what age did you have your first period?

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

Clinical findings

# Clinical findings

**Additional tests:**

**Significant test results/trends:**

**Action plan:**

*(including advice literature given)*

Doctor's signature \_\_\_\_\_

Date \_\_\_\_\_

