



Bupa Mature Health

Please complete this questionnaire and bring it with you



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

Important information for women about cervical smear screening

Important information for men about PSA testing

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

Clinical findings

Your general health

Have you ever had any of the following vaccinations?

Flu Yes No When?

Tetanus Yes No When?

Pneumococcal Yes No When?

Do you have any problems in any of the following areas that you would like to discuss with your Bupa doctor?

Please mark with a tick any areas for discussion and add any notes in the space provided.

| | |
|--------------------------------|--------------------------|
| Eyes | <input type="checkbox"/> |
| Ears, nose, throat | <input type="checkbox"/> |
| Mouth, teeth | <input type="checkbox"/> |
| Skin | <input type="checkbox"/> |
| Glands | <input type="checkbox"/> |
| Breathing | <input type="checkbox"/> |
| Cough, phlegm | <input type="checkbox"/> |
| Asthma | <input type="checkbox"/> |
| Bronchitis | <input type="checkbox"/> |
| Headaches | <input type="checkbox"/> |
| Sleep | <input type="checkbox"/> |
| Stress | <input type="checkbox"/> |
| Tiredness | <input type="checkbox"/> |
| Muscles | <input type="checkbox"/> |
| Joints | <input type="checkbox"/> |
| Osteoporosis | <input type="checkbox"/> |
| Arm pain | <input type="checkbox"/> |
| Palpitations | <input type="checkbox"/> |
| High blood pressure | <input type="checkbox"/> |
| Poor circulation | <input type="checkbox"/> |
| Weight | <input type="checkbox"/> |
| Appetite, digestion | <input type="checkbox"/> |
| Difficulty swallowing | <input type="checkbox"/> |
| Abdominal pain | <input type="checkbox"/> |
| Change in bowel action | <input type="checkbox"/> |
| Blood or mucus in motions | <input type="checkbox"/> |
| Blood in urine | <input type="checkbox"/> |
| Pain passing urine | <input type="checkbox"/> |
| Incontinence, losing urine | <input type="checkbox"/> |
| Sexual matters or problems | <input type="checkbox"/> |
| Sexually transmitted infection | <input type="checkbox"/> |
| Other | <input type="checkbox"/> |

Clinical findings

Please tell us about yourself and your family

Clinical findings

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 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

Do any of your children live nearby? Yes No

Are they healthy? Yes No

Family history

Has there been a change in the health status of any members of your family since your last visit? Yes No
 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"/> |

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 |
|-----------------|--------------------------|--------------------------|----------------------|
| Alcoholism | <input type="checkbox"/> | <input type="checkbox"/> | <input type="text"/> |
| Aortic aneurysm | <input type="checkbox"/> | <input type="checkbox"/> | <input type="text"/> |
| Bowel cancer | <input type="checkbox"/> | <input type="checkbox"/> | <input type="text"/> |
| Breast cancer | <input type="checkbox"/> | <input type="checkbox"/> | <input type="text"/> |
| Ovarian cancer | <input type="checkbox"/> | <input type="checkbox"/> | <input type="text"/> |
| Prostate cancer | <input type="checkbox"/> | <input type="checkbox"/> | <input type="text"/> |

Family history *(continued)*

| | Yes | No | Details |
|---------------------------------|-----|----|---------|
| Diabetes | | | |
| Epilepsy | | | |
| Glaucoma | | | |
| Heart attack | | | |
| Angina or heart surgery | | | |
| High blood pressure | | | |
| Mental illness | | | |
| Osteoporosis | | | |
| Skin cancer, malignant melanoma | | | |
| Stroke | | | |
| Thyroid disease | | | |

Any other comments or queries about family history

Your job history

Are you currently working? Full-time Part-time Retired

If so, what is the job and how many hours do you work?

What sort of occupation have you had in the past?

Do you have any hobbies, for example reading, DIY etc?

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)

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

Would you describe yourself as: Sedentary

Mildly active

Active

How much walking do you do each day?

Please specify how many minutes each walk takes

Are you regularly active in other ways?

Briefly describe any exercise or physical activity you take and how often

Has your level of activity changed for any reason like illness etc?

If yes, please give details

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 = Sedentary

2 = Mildly active

3 = Active

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, eggs and fatty meats

Yes No

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?

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

Yes No

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

Your medical history

| | Yes | No | Details |
|--|--------------------------|--------------------------|---------|
| Have you ever had a heart attack? | <input type="checkbox"/> | <input type="checkbox"/> | |
| Have you ever felt any pressure or heaviness in your chest? | <input type="checkbox"/> | <input type="checkbox"/> | |
| Have you ever had chest pain or any other heart problems? | <input type="checkbox"/> | <input type="checkbox"/> | |
| Have you ever noticed your heart beating abnormally? | <input type="checkbox"/> | <input type="checkbox"/> | |
| Have you ever had high blood pressure? | <input type="checkbox"/> | <input type="checkbox"/> | |
| Have you ever had a raised cholesterol level? | <input type="checkbox"/> | <input type="checkbox"/> | |
| Do you suffer from dizziness or fainting spells? | <input type="checkbox"/> | <input type="checkbox"/> | |
| Do your ankles ever swell? | <input type="checkbox"/> | <input type="checkbox"/> | |
| Do you suffer from leg pains after walking a short distance? | <input type="checkbox"/> | <input type="checkbox"/> | |
| Do you get out of breath easily? | <input type="checkbox"/> | <input type="checkbox"/> | |

Have you had any major illnesses, operations or accidents since your last visit?

Yes No

If yes, please give details

Your medical history *(continued)*

If this is your first Bupa health assessment, please complete this section.

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

| | Yes | No | Details |
|--|-----|----|---------|
| Stroke | | | |
| Deep vein thrombosis | | | |
| Kidney problems, stones | | | |
| Cystitis (urine infection) | | | |
| Bronchitis, emphysema | | | |
| Asthma | | | |
| Tuberculosis | | | |
| Pneumonia, pleurisy | | | |
| Peptic ulcer, indigestion | | | |
| Jaundice, hepatitis | | | |
| Gallstones | | | |
| Piles or fissures | | | |
| Polyps in colon | | | |
| Colitis, irritable bowel | | | |
| Diabetes | | | |
| Thyroid problems | | | |
| Mumps | | | |
| Blood disorder eg anaemia | | | |
| Malaria | | | |
| Other tropical diseases | | | |
| Mental problems | | | |
| Depression | | | |
| Anxiety | | | |
| Fits, epilepsy, blackouts | | | |
| Migraine, recurrent headaches | | | |
| Concussion, head injury | | | |
| Cancer | | | |
| Other glandular disorders | | | |
| Problems with veins, varicose veins | | | |
| Glaucoma | | | |
| Ear disease or discharge | | | |
| Skin problems eg eczema | | | |
| Back problems | | | |
| Arthritis, gout | | | |
| Bone fractures, osteoporosis | | | |
| Muscle or nerve disease | | | |
| Sexually transmitted infections eg chlamydia | | | |
| Prostate or bladder problems | | | |
| Hernia operation | | | |
| Any other operations | | | |
| Accident, injuries | | | |
| Sterilisation, vasectomy | | | |
| Blood transfusion | | | |

Clinical findings

Your medical history *(continued)*

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

Have you had any trips or falls recently?

Yes No

If yes, please give details

Have you suffered from any dizziness, faints or black-outs recently?

Yes No

If yes, please give details

Do you have any problems with your feet or footwear?

Yes No

If yes, please give details

Have you had any recent problems with finding things or remembering new information like arrangements for appointments, names, or addresses? Yes No

If yes, please give details

Clinical findings

Your wellbeing

This section is a series of questions specially designed to see how you are feeling generally about your health and circumstances.

Please answer all the questions by either ticking "Yes" or "No"

- | | | |
|---|------------------------------|-----------------------------|
| Are you basically satisfied with your life? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Have you dropped many of your activities and interests? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Do you feel that your life is empty? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Do you often get bored? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Are you hopeful about the future? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Are you bothered about thoughts you can't get out of your head? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Are you in good spirits most of the time? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Are you afraid that something bad is going to happen to you? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Do you feel happy most of the time? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Do you often feel helpless? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Do you often get restless and fidgety? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Do you prefer to stay at home rather than go out and do new things? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Do you frequently worry about the future? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Do you feel that you have more problems with memory than most people? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Are you enjoying life now? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Do you feel downhearted and blue? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Do you often feel worthless the way you are now? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Do you worry a lot about the past? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Do you find life very exciting? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Is it hard for you to get started on new projects? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Do you feel full of energy? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Do you feel that your situation is hopeless? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Do you think that most people are better off than you are? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Do you frequently get upset over little things? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Do you frequently feel like crying? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Do you have trouble concentrating? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Do you enjoy getting up in the morning? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Do you prefer to avoid social gatherings? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Is it easy for you to make decisions? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Is your mind as clear as it used to be? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

Clinical findings

Score

Health questions for women

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.

Have you ever had a cervical smear? Yes No

If yes, when was your last cervical smear? Year

Have you ever had an abnormal smear? 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 details

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

Is breast tenderness a problem? Yes No

If yes, please give details

When was your last period? Year

Do you have any sexual problems? Yes No

Do you have problems with vaginal discharge or bleeding? Yes No

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

If yes, please give age and details

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

Have you ever been pregnant? Yes No

If yes, please give details

Clinical findings

Parity: +

Age FFTP _____

Details

Health questions for men

Do you regularly examine your testes?

Yes No

Have you ever noticed any lumps or swellings in your testes?

Yes No

Do you get up at night to pass urine on a regular basis?

Yes No

If yes, how many times a night?

Have you noticed any change in the flow rate or stream of your urine?

Yes No

Do you have difficulty in starting and stopping passing urine?

Yes No

Do you have any problems with sexual function?

Yes No

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

Clinical findings

Notes

Consent and previous visits

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

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

| | |
|----------------------|------------------------|
| Previous visit date: | Previous abnormalities |
| Blood pressure: | |
| Weight: | |
| BMI: | |
| Body fat percentage: | Previous action points |
| PSA TSH: | |
| Activity level: | |
| Total cholesterol: | |
| HDL cholesterol: | |

Clinical findings

NORMAL
ABNORMAL

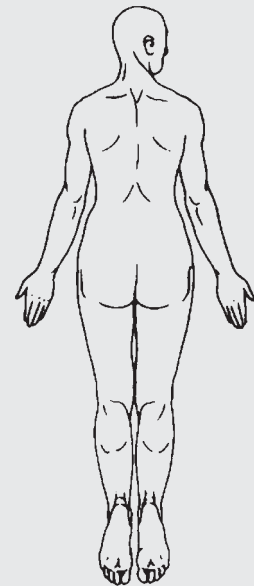
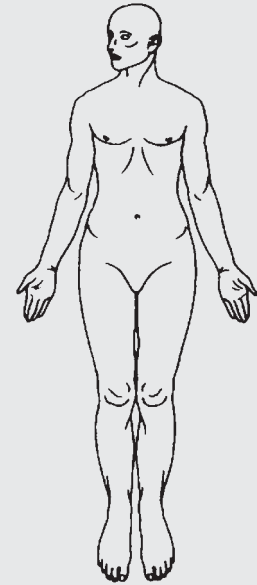
| | NORMAL | ABNORMAL |
|------------------------------|--------|----------|
| Eyes/fundi | | |
| Ears and nose | | |
| Teeth and gums | | |
| Mouth and throat | | |
| Skin | | |
| Lymph glands | | |
| Central NS | | |
| Peripheral NS | | |
| Heart size | | |
| Heart rhythm | | |
| Heart sounds | | |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

Build/shape:

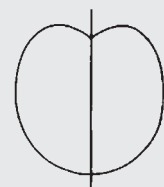
Pulse/rhythm:

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"/> | <input type="checkbox"/> |

Doctor's signature _____

Date _____

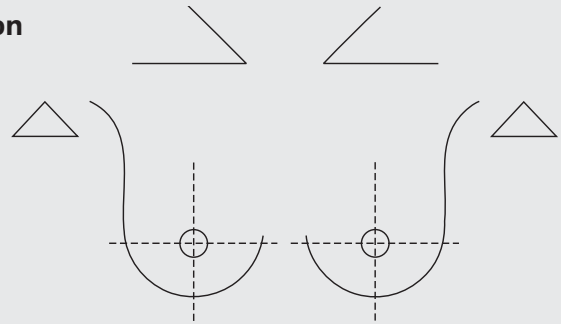
Health adviser's signature _____

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)

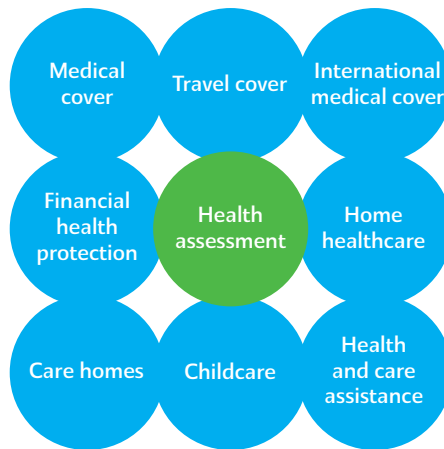
| Clinical summary: | Right | Left | | Right | Left |
|-------------------|------------------------------|-----------------------------|------------------|--------------------------|--------------------------|
| Normal | <input type="checkbox"/> | <input type="checkbox"/> | Nipple normal | <input type="checkbox"/>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

GYNAECOLOGICAL symptoms and assessment

| Clinical | | | | | | | | | |
|------------|----------------------------------|-----------------------------------|------------------------------------|--|------------------------------------|--|--|---|--|
| Abdomen: | Normal <input type="checkbox"/> | Abnormal <input type="checkbox"/> | Vulva: | Normal <input type="checkbox"/> | Abnormal <input type="checkbox"/> | | | | |
| Vagina: | Normal <input type="checkbox"/> | Atrophic <input type="checkbox"/> | Intacta <input type="checkbox"/> | Prolapse <input type="checkbox"/> | Discharge <input type="checkbox"/> | | | | |
| Cervix: | Normal <input type="checkbox"/> | Atrophic <input type="checkbox"/> | Cont. Bld <input type="checkbox"/> | Absent <input type="checkbox"/> | Polyp <input type="checkbox"/> | | | Nab foll. <input type="checkbox"/> | |
| | Ectopia <input type="checkbox"/> | Suspic. <input type="checkbox"/> | | Cervix fully visualised <input type="checkbox"/> | | | | 360° sweep taken <input type="checkbox"/> | |
| Uterus: | Normal <input type="checkbox"/> | Abnormal <input type="checkbox"/> | Absent <input type="checkbox"/> | Mobile <input type="checkbox"/> | Fixed <input type="checkbox"/> | | | | |
| Position: | A/V <input type="checkbox"/> | R/V <input type="checkbox"/> | Axial <input type="checkbox"/> | | | | | | |
| Adnexae: | Normal <input type="checkbox"/> | Abnormal <input type="checkbox"/> | | | | | | | |
| Cx. Smear: | Yes <input type="checkbox"/> | No <input type="checkbox"/> | Vault <input type="checkbox"/> | | | | | | |
| HVS: | Yes <input type="checkbox"/> | No <input type="checkbox"/> | | | | | | | |



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

