



# Bupa Mature Health

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Please complete this questionnaire and bring it with you



# Your health assessment questionnaire

ID number

The Bupa Mature Health Assessment has been designed to help you look after your health by providing a detailed picture of how healthy you are now, 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 this is your **first** Bupa Mature Health Assessment, please also complete the **dark green section on page 8**.
- If you have been for a Bupa Later Life Health Assessment **before**, please use the **light green sections** to indicate changes since your last visit.
- 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"/>				
	<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 (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

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

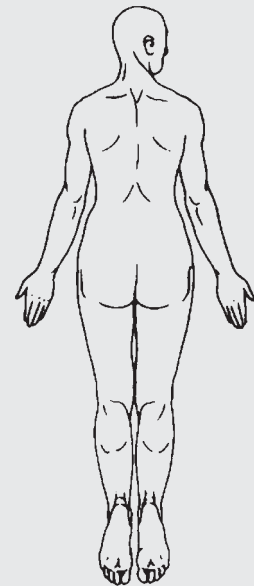
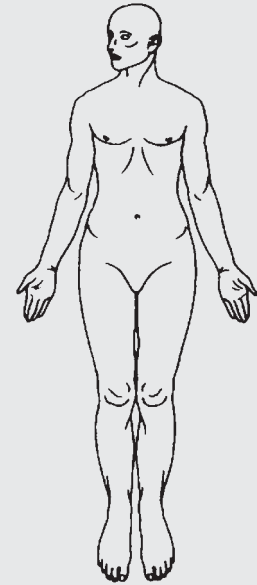
	NORMAL	ABNORMAL
Eyes/fundi		
Ears and nose		
Teeth and gums		
Mouth and throat		
Skin		
Lymph glands		
Central NS		
Peripheral NS		
Heart size		
Heart rhythm		
Heart sounds		
Carotid sounds		
Peripheral arteries		
Veins		
Upper resp. tract		
Lungs		
Abdominal palpation		
Abdominal organs		
Liver		
Hernial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

Build/shape:

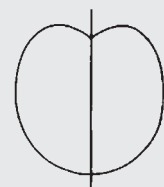
Pulse/rhythm:

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:**

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**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		
<b>Point total</b>		
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 \_\_\_\_\_

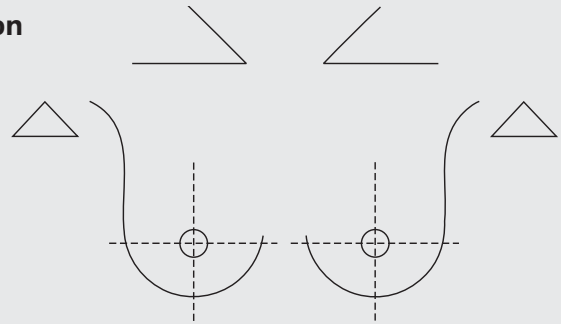
Health adviser's signature \_\_\_\_\_

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)

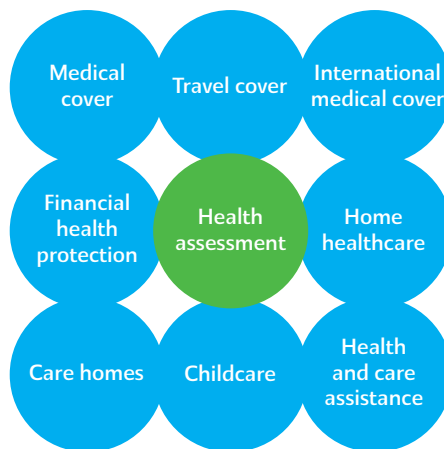
Clinical summary:	Right	Left		Right	Left
Normal	<input type="checkbox"/>	<input type="checkbox"/>	Nipple normal	<input type="checkbox"/>	<input type="checkbox"/>
Benign abnorm.	<input type="checkbox"/>	<input type="checkbox"/>	Nipple inverted	<input type="checkbox"/>	<input type="checkbox"/>
Suspic. 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](http://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](http://www.bupa.com)

