



Bupa Ovarian Health

Please complete this questionnaire and bring it with you



Your health check questionnaire

ID number

The Bupa Ovarian Health check has been designed to detect any possible ovarian problems.

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"/>	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"/>						

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):

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 your results 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 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"/>		

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 ovarian health information sheet

(please tick):

Please sign

Date

Clinical findings

Please tell us your reason for attending

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.

Family history

Has any parent, grandparent, sister, aunt, suffered or died from any of the following?
If yes, please give details and ages as appropriate.

	Yes	No	Details
Bowel cancer or polyps	<input type="checkbox"/>	<input type="checkbox"/>	
Breast cancer	<input type="checkbox"/>	<input type="checkbox"/>	
Ovarian cancer	<input type="checkbox"/>	<input type="checkbox"/>	

Your lifestyle

Smoking

Do you smoke? Never Given up Yes

Alcohol

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)

Diet

How often do you eat red meat, including beef, lamb and pork?

Please specify eg daily, weekly etc

How often do you eat processed meat including ham, bacon, salami, sausages etc?

Please specify

How often do you eat fish, excluding shellfish?

Please specify

How often do you eat cheese, cream, butter and yoghurt?

Please specify

Your lifestyle *(continued)*

How often do you eat chocolate and confectionery?

Please specify

How often do you eat snack foods, including crisps and roasted nuts?

Please specify

Your medical history

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

	Yes	No	Details
Glands			
Tiredness			
Weight			
Abdominal pain or bloating			
Change in bowel action			

When was your last period?

Date / /

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

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

	Yes	No	Details
Have you ever been on the contraceptive pill?			
Have you ever taken fertility drugs eg Clomid?			
Have you been on androgen treatment?			
Have you been on oestrogen replacement?			

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

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

Additional tests:

Significant test results/trends:

Action plan:

(including advice literature given)

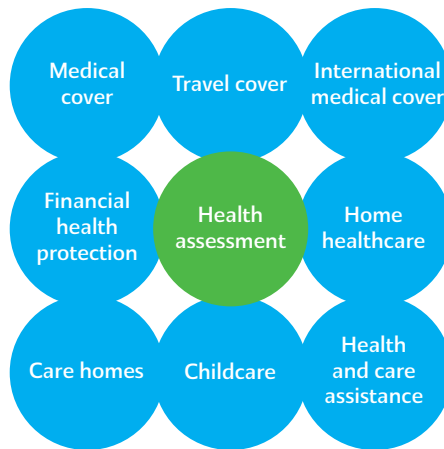
Comments for GP:

Doctor's signature _____

Date _____

Ultrasonographer's signature _____

Date _____



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