



# Bupa Wellbeing Check (SH)

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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 Sexual Health check has been designed to help you look after your sexual health and to address any sexual health issues you may have.

**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	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"/>			
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"/>					

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 results to your GP 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"/>					

## Information sheets

It is important to have read the information sheet on sexual health to understand the tests we will carry out on you

I confirm that I have received and read the sexual health information sheet (please tick):

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"/>		

## Please tell us your reason for attending

Clinical findings

## Please tell us about your sexual history

Do you have sex with:                      Women                       Men                       Both

Do you participate in:                      Vaginal sex                       Anal sex                       Oral sex

Do you use a condom or barrier:                      Always                       Sometimes                       Never

Do you use drugs?    Yes     No

Do you have sex when using drugs or alcohol?    Yes     No

Have you had:

Syphilis       Genital warts       Gonorrhoea       Chlamydia       Herpes

HIV       Hepatitis A       Hepatitis B       Hepatitis C

### Your symptom history:

Yes    No    Details

	Yes	No	Details
Do you have any related pain?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have a discharge?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have a genital rash or colour change?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have itching?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have bleeding?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have a lump anywhere?	<input type="checkbox"/>	<input type="checkbox"/>	

## Your medical history

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

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

# 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

NORMAL  
ABNORMAL

Mouth and throat	<input type="checkbox"/>	<input type="checkbox"/>
Abdominal palpation	<input type="checkbox"/>	<input type="checkbox"/>
Rectum	<input type="checkbox"/>	<input type="checkbox"/>
Female genitalia	<input type="checkbox"/>	<input type="checkbox"/>
Male genitalia	<input type="checkbox"/>	<input type="checkbox"/>

## Tests Performed:

### Male

- Urethral Swab
- Chlamydia
- Gonorrhoea
- Herpes Simplex 1+2
- Hepatitis B
- Hepatitis C
- HIV
- Syphilis

### Female

- Vaginal Swab
- Chlamydia
- Gonorrhoea
- Herpes Simplex 1+2
- Hepatitis B
- Hepatitis C
- HIV
- Syphilis

## Significant results/trends

**Treatment Plan :**  
*(including advice literature given)*

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

Date \_\_\_\_\_

