YOUR FITNESS ASSESSMENT QUESTIONNAIRE

www.bupa.com

PLEASE COMPLETE THIS QUESTIONNAIRE AND BRING IT WITH YOU

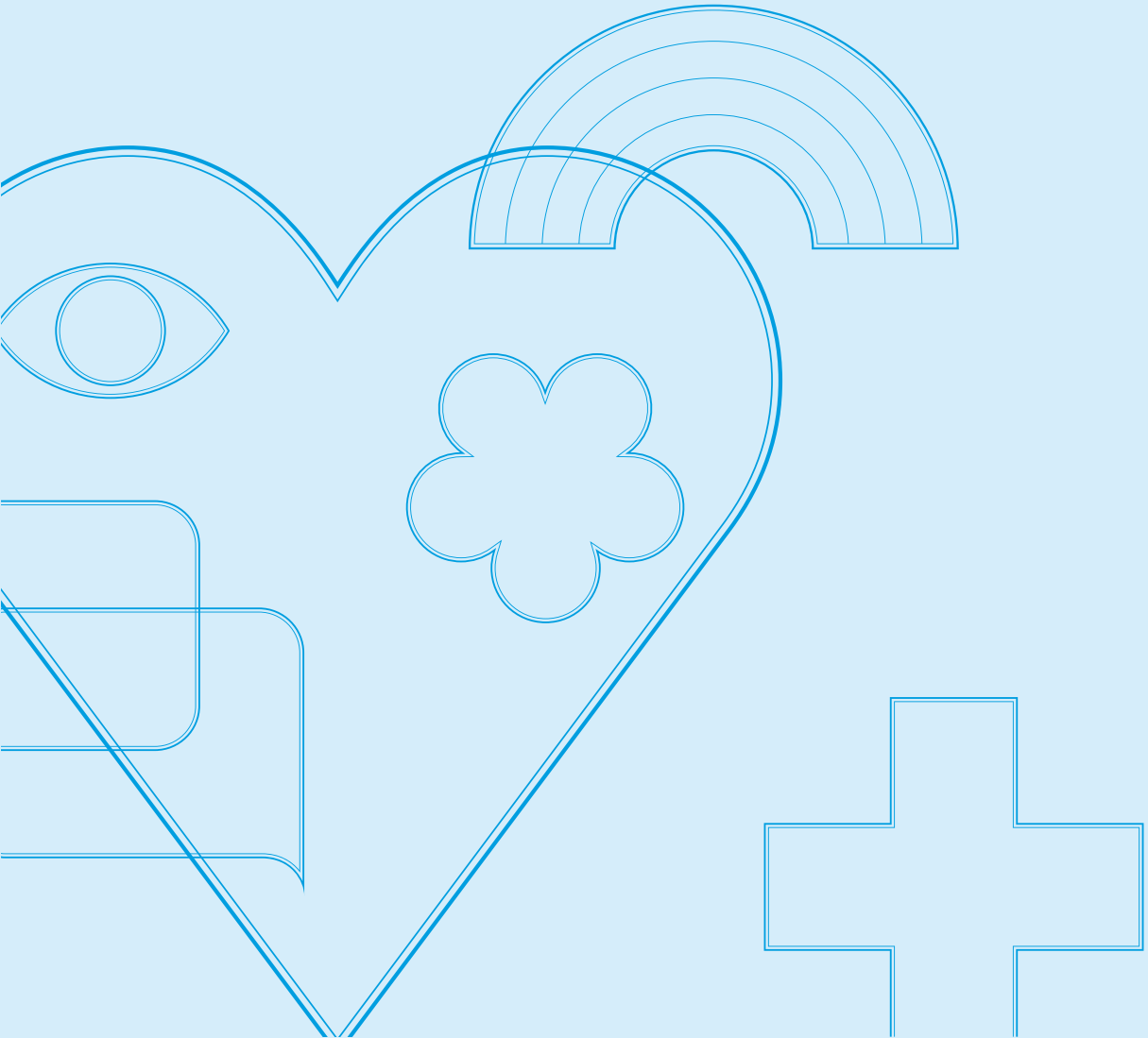
ID NUMBER

The Bupa Fitness Assessment is designed to gain a detailed analysis of your current fitness. It will provide tailored advice to help you meet your fitness goals based upon your cardio-respiratory responses. As part of your assessment we ask that you complete the following questionnaire as comprehensively as possible. This is to ensure that you get the most out of your assessment and to reduce any risks associated with completing the fitness test.

You should complete the blue sections of this confidential questionnaire as fully as possible and bring it with you to your fitness assessment. 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 PERSONAL DETAILS

Title *(Mr, Mrs, Miss, Ms, other title)*

First name

Surname

Address

Postcode

Home telephone number

Work telephone number

Mobile telephone number

Email address

Are you covered by private medical insurance? Bupa ◯ Membership number Other ◯ No ◯

Date questionnaire completed / /

Please complete the following if your employer is paying for this assessment:

Company name

Company address

Postcode

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

GP address

Postcode

GP telephone number

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 ◯ No ◯ Your GP Yes ◯ No ◯

Please sign Date / /

This visit date

Name of doctor

First visit Yes ◯ No ◯

Name of health adviser

If no, date of last visit

YOUR MEDICAL HISTORY

If this is your first Bupa Fitness Assessment, please complete this section.

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

Diagnosed heart conditions or diagnosed cardiac conditions including: myocardial infarction, unstable angina, atrial flutter or atrial fibrillation, left bundle branch block, Wolff Parkinson White syndrome or second or third degree heart block	
Diagnosed diastolic murmur	
Diagnosed aortic stenosis	
Diagnosed congenital heart disease	
Diagnosed aortic aneurysm	
Palpitations	
Arm pain	
High blood pressure	
Stroke	
Asthma	
Bronchitis, emphysema	
Other	

The Bupa Fitness Assessment, does not require you to work to complete exhaustion, but does require you to exert yourself on an exercise bike for between 6-20 minutes. It is important that we are aware of any contraindications to exercise to avoid the risk of injury or more serious issues. Please indicate any relevant medical history below. If you are unsure, please discuss with your GP prior to completing this section.

Have you ever had any heart condition (including high blood pressure) that has required treatment from your doctor?	Yes ◯	No ◯
Do you have diabetes?	Yes ◯	No ◯

In the past year, have you suffered from or been unable to work because of any of the following: (If yes, approximately how many days were you unable to work?)

	Yes	No	No. of days not worked
a. Back pain	◯	◯	
b. Other muscle or joint pain	◯	◯	
c. Colds, influenza, virus infection	◯	◯	
d. Period pain, PMT	◯	◯	
e. Gastric upsets (nausea, diarrhoea, vomiting)	◯	◯	
f. Stress	◯	◯	
g. Injury	◯	◯	
h. Accidents	◯	◯	
i. Assault	◯	◯	
j. Other illness	◯	◯	

YOUR MEDICAL HISTORY (CONTINUED)

Other
Please note any other conditions that you have had diagnosed by a doctor

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

YOUR REASONS FOR ATTENDING

Please tell us your main reasons for attending

Please outline below what you would like to get out of your Bupa Fitness Assessment (fitness goals, a specific event you are competing in etc...)

Your Bupa Fitness Assessment includes a number of tests designed to help you understand your current fitness status and how your lifestyle affects your fitness levels and future health risks. As with most medical tests and services it is not always possible to detect all potential problems. If any medical symptoms you have do not resolve as expected or any new symptoms arise, you should seek further medical advice.

YOUR GENERAL HEALTH AND FITNESS

YOUR EXERCISE AND ACTIVITY

How much aerobic exercise do you take?

(By aerobic exercise we mean activity that raises your heart rate and makes you slightly breathless)

20 minutes or more four or more times a week	◯
20 minutes or more three times a week	◯
20 minutes or more once or twice a week	◯
Less than once a week	◯

Are you a member of a gym? Yes ◯ No ◯

Are you generally active as part of your daily routine? Yes ◯ No ◯

eg do you walk a lot, do you use the stairs instead of the lift, are you a keen gardener?

Please give details of activities you take, your health goals or any events that you are training for

YOUR DIET

Do you limit the amount of refined sugar in your diet?

eg 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 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 many cups of caffeinated drink do you drink a day?

ie tea, coffee, energy drinks

Has your weight been steady recently?

Yes ◯ No ◯

Any other concerns or comments about your diet or weight?

☐

EXERCISE
Mark box
1 = Less than once a week
2 = 1-2 times a week
3 = 3 times a week
4 = 4 or more times a week

Clinical findings

YOUR LIFESTYLE

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)

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

☐

CIGARETTES
Mark box
1 = Never
2 = Ex
3 = Currently

☐

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

PHYSIOLOGIST NOTES

Health adviser's signature _____

Date _____

Call 0800 600 500
for information on all
other Bupa services.

Lines open 8am–8pm
Monday to Friday
9am–5pm on Saturday.

Calls may be recorded
and may be monitored.

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Health Limited.

Registered in England and Wales
No. 631336.

Registered Office: Bupa House,
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