Medical data capture form

10 most commonly disclosed medical conditions

Guidance

This form contains the supplementary questions that our online application system will ask for the 10 most common medical disclosures. Please indicate which condition(s) affect you and answer the questions that apply. Your Adviser will then transfer this information onto our online application system.

Please note: Before you complete this form we recommend saving a copy of this PDF to a location on your computer, device or network before you start filling in any details.

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Please confirm before completing this form

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◯ **Yes**	◯ **No**

Asthma

(Mild asthma, allergic asthma, seasonal asthma)

Q1. Have you had breathing problems or chest pain in the last two years which have caused any of the following:

Difficulty walking for 200m	◯ Yes	◯ No
Breathlessness or wheezing even when resting	◯ Yes	◯ No
You have needed to use home oxygen treatment	◯ Yes	◯ No
None of these	◯ Yes	◯ No

Q2. Have you been admitted to hospital or visited A&E in the last two years with asthma or breathing problems? ◯ Yes ◯ No

If the answer is yes, please tell us the:

- number of admissions/visits and dates
- treatment you had, symptoms and length of stay
- current treatment prescribed (tablets and inhalers)
- number of days of usual activity/work affected in the last two years.

Q3. Have you been prescribed steroid tablets (sometimes called Prednisolone) in the last 12 months?

If yes we'd like to know the total number of days you have been prescribed this treatment, they do not need to be consecutive days.

Yes, steroid tablets for 7 days or less	◯ Yes	◯ No
Yes, steroid tablets for 8 to 28 days	◯ Yes	◯ No
Yes, steroid tablets for more than 28 days	◯ Yes	◯ No
No steroid tablets	◯ Yes	◯ No

If the answer is 'yes, steroid tablets for more than 28 days', please tell us about your current prescribed treatment (tablets and inhalers):

- how many weeks on steroid tablets
- the number of days of usual activity/work affected in the last 12 months.

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Q4. How many days have you taken off work because of this condition in the last 12 months?

Q5. How often do you have symptoms?

Please select the answer which best describes your symptoms over the last month. (Symptoms include wheezing, shortness of breath, a tight chest or coughing.)

A. Four or more times a week	◯ Yes	◯ No
B. Fewer than four times a week but have had symptoms every week	◯ Yes	◯ No
C. Occasional symptoms (can go a week without any symptoms)	◯ Yes	◯ No

Q6. Have you had to take your medication more often or has the dose increased or type of medication changed in the last year? (Please don't answer this question if you answered yes to Q5 B. or Q5 C.)

◯ Yes ◯ No

If you are aged 50 or above, please answer the following questions

Q7. Have you had any of these conditions?

Chronic obstructive pulmonary disease (COPD)	◯ Yes	◯ No
Chronic obstructive airways disease (COAD)	◯ Yes	◯ No
Chronic bronchitis	◯ Yes	◯ No
Emphysema	◯ Yes	◯ No
Not sure	◯ Yes	◯ No
None of these	◯ Yes	◯ No

Q8. How many chest infections have you had in the last two years; including attacks of bronchitis and lower respiratory tract infections?

Q9. Do any of the following apply to your symptoms?

First started in the last six months	◯ Yes	◯ No
Have become more frequent or severe in the last six months	◯ Yes	◯ No
None of these	◯ Yes	◯ No

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Backache

(Back pain, sciatica, whiplash, slipped disc, back injury, bad back)

Q1. Are you awaiting any of the following?

Hospital referral (other than for physiotherapy)	◯ Yes	◯ No
Investigations, tests or results	◯ Yes	◯ No
An operation	◯ Yes	◯ No
None of these	◯ Yes	◯ No

Please advise what operation you have planned and when it is due to take place

Q2. Is your back problem related to any of the following?

Ankylosing spondylitis	◯ Yes	◯ No
Cauda equina syndrome	◯ Yes	◯ No
Spinal curvature or scoliosis	◯ Yes	◯ No
None of these	◯ Yes	◯ No

Q3. Which of the following best describes the severity of your condition?

No current symptoms	◯ Yes	◯ No
Minor symptoms (e.g. early morning stiffness, occasional mild pain) with no effect on your mobility or activities/pastimes	◯ Yes	◯ No
Regular pain, affects your participation in activities or pastimes	◯ Yes	◯ No
Severe pain, activities often restricted, mobility aids needed, e.g. walking stick	◯ Yes	◯ No
Symptoms are very severe, e.g. bedridden, experience problems dressing or washing, wheelchair use	◯ Yes	◯ No

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If Care Cover is being applied for, please answer the following question:

Q4. Please provide more details about your condition including the frequency and severity of symptoms, how they affect your everyday life, treatment, dates and the results of any investigations.

Q5. When did you last have symptoms of this condition?

Q6. Where did you suffer pain?
(Please tick all that apply)

Neck	◯ Yes	◯ No
Back	◯ Yes	◯ No
Both back and neck	◯ Yes	◯ No

Q7. How many days off work have you had with this condition in the last 2 years?

Q8. On how many separate occasions have you experienced symptoms?

Depression

(Stress, anxiety, panic attacks, post-traumatic stress, work-related stress)

If you are aged 65 or above, please answer Q1 and Q2 before continuing. For all other ages, please move to on Q3.

Q1. Have you had any of these in the last 5 years?
Please tell us about these even if you haven't seen a medical professional.

A. Memory loss	◯ Yes	◯ No
B. Confusion	◯ Yes	◯ No
C. Changes to your concentration levels	◯ Yes	◯ No
D. Changes to communication skills	◯ Yes	◯ No
E. None of these	◯ Yes	◯ No

Q2. If you selected A, B, C or D, have you seen or spoken to a doctor, specialist or another medical professional about this? If so, please provide full details.

For all age groups disclosing depression, stress, anxiety, panic attacks, post-traumatic stress, work-related stress, please answer the following questions:

Q3. In the past 5 years have you seen the community mental health team, crisis team or been admitted to hospital or a clinic, including A&E in relation to your mental health? ◯ Yes ◯ No

Q4. In the past 5 years, who have you seen for this condition?
(These can face-to-face, over the phone or virtual/online).

A. Doctor or nurse at my surgery	◯ Yes	◯ No
B. Cognitive behavioural therapist (CBT)	◯ Yes	◯ No
C. Counsellor	◯ Yes	◯ No
D. Psychologist or psychotherapist	◯ Yes	◯ No
E. Psychiatrist	◯ Yes	◯ No
F. Drug support worker/specialist	◯ Yes	◯ No
G. Alcohol support worker/specialist	◯ Yes	◯ No
H. None of these	◯ Yes	◯ No

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Q5. If you selected D, E, F or G, when did you last attend or speak to a drug, alcohol support worker/specialist, psychiatrist, psychiatric nurse, psychologist or psychotherapist?

Q6. When did you first see or speak to a medical professional about your mental health? If you haven't seen a medical professional, then please use the date at which you first became aware of a change in your mood or felt your mental health was starting to be impacted in a negative way.

Q7. Please tell us about your treatment:

I'm currently taking or have been advised to take anti-depressant treatment e.g. Citalopram, Fluoxetine, Paroxetine, Sertraline	◯ Yes	◯ No
I'm currently taking or have been advised to take anti-psychotic treatment e.g. Aripiprazole, Chlorpromazine, Olanzapine, Risperidone	◯ Yes	◯ No
I'm currently taking or have been advised to take a mood stabiliser e.g. Lamotrigine, Lithium, Valproate	◯ Yes	◯ No
None of these	◯ Yes	◯ No

Q8. In the past 12 months, have you been told to do any of these? (Please tick all that apply)

I was told to start treatment	◯ Yes	◯ No
I was told to change my treatment to help manage my symptoms	◯ Yes	◯ No
I was told to increase my treatment	◯ Yes	◯ No
I was told to reduce or stop my treatment	◯ Yes	◯ No
None of these	◯ Yes	◯ No

Q9. Are you currently off work or have you been off work for more than 5 days in the last 3 months? If you don't work, you can answer 'no' to this question. ◯ Yes ◯ No

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Q10. In the past 2 years, how many weeks off work have you taken for this? If you don't work, let us know how many weeks you struggled to do your normal daily jobs.

Q11. When did you last have symptoms of low mood, consult a medical professional about mental health symptoms or feel that your mental health was being impacted in a negative way?

Q12. We understand this is a sensitive question but it's needed to help us understand your mental health history a bit better:

In the past 10 years, have you:

A. Harmed yourself	◯ Yes	◯ No
B. Thought about harming yourself	◯ Yes	◯ No
C. Tried to end your life, including overdose attempts	◯ Yes	◯ No
D. Thought about ending your life	◯ Yes	◯ No
E. None of these	◯ Yes	◯ No

Q13. If you selected A, B, C or D, when did you last try to harm yourself, think about harming yourself, or attempted to take your own life?

Q14. How many times have you thought about or attempted to take your own life?

Q15. Please provide full details of your mental health condition, how this is managed and how it affects you. We'd like to use your insight to help us understand your mental health.

Diabetes mellitus

(Type 1 or 2 diabetes, insulin or non insulin dependent diabetes)

If the answer to Q1 is yes, you will also need to complete page 17:

Q1. Do you also have raised blood pressure? ◯ Yes ◯ No

If the answer to Q2 is yes, you will also need to complete page 19:

Q2. Do you also have raised cholesterol? ◯ Yes ◯ No

Q3. Apart from your regular check-ups, are you waiting for a hospital referral, tests or investigations, or the results of these? ◯ Yes ◯ No

Q4. At what age were you diagnosed with diabetes?

(If you are not diagnosed with diabetes, the age you were found to have raised blood sugar.)

Q5. Have you been diagnosed with diabetes within the last six months? ◯ Yes ◯ No

Q6. If you answered yes to Q5, please answer:

What was your HbA1c reading on diagnosis?

1. 8.0% (64 mmol/mol) or under ◯ Yes ◯ No
2. 8.1% (65 mmol/mol) or over ◯ Yes ◯ No
3. Don't know ◯ Yes ◯ No

Q7. Was your last diabetes review within the last year? ◯ Yes ◯ No

If your smoker status is smoker, please answer Q8 below

Q8. On average, how many cigarettes do you smoke per day?

Q9. Please tick all that apply to you:

I've had angina, a heart attack or heart disease	◯ Yes	◯ No
I've had a stroke or mini stroke	◯ Yes	◯ No
I've had kidney disease or reduced kidney function	◯ Yes	◯ No
I've had foot or leg problems which needed treatment or surgery due to diabetes	◯ Yes	◯ No
None of these	◯ Yes	◯ No

Q10. Have you ever had any of the following symptoms or conditions?

(Please tick all that apply)

I've had protein or blood in the urine	◯ Yes	◯ No
I've had altered sensation or abnormal pulses in my feet	◯ Yes	◯ No
I've had eye problems due to diabetes	◯ Yes	◯ No
I've been to hospital for very low or very high amounts of sugar in my blood in the last 12 months	◯ Yes	◯ No
None of these	◯ Yes	◯ No

Q11. At your last diabetic review, what were you told about the control of your diabetes and treatment?

Example:

- Excellent control HbA1c of 7.0% (53mmol/mol) or less
- Satisfactory control HbA1c of 7.1% (54mmol/mol) to 8.0% (64mmol/mol)
- Less than satisfactory control HbA1c of 8.1% (65mmol/mol) or above

Excellent control, no change to treatment needed	◯ Yes	◯ No
Satisfactory control, no change to treatment needed	◯ Yes	◯ No
Satisfactory control, treatment increased or changed	◯ Yes	◯ No
Advised diabetic control was less than satisfactory or needed improvement	◯ Yes	◯ No
I don't know	◯ Yes	◯ No

If you answered 'don't know' in Q11, then please answer Q12

Q12. How often have you consulted with a medical professional for your diabetes in the last year?

Once	◯ Yes	◯ No
Twice	◯ Yes	◯ No
Three times or more	◯ Yes	◯ No

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If you had answered Yes to Advised diabetic control was less than satisfactory or needed improvement in Q11, please answer Q13.

Q13. Has your HbA1c reading been over 10% (or 86 mmol) in the last 2 years?

Yes	◯ Yes	◯ No
No	◯ Yes	◯ No
Don't know	◯ Yes	◯ No

Growths, cysts, lumps etc

(Cyst, lump, mole, polyp, fatty lump, growth)

Q1. Has the cyst, lump or growth or polyp been removed?

It has been completely and totally removed	◯ Yes	◯ No
It disappeared, or was drained without surgery	◯ Yes	◯ No
It's still present or has only partially been removed	◯ Yes	◯ No
Q2. Are you awaiting an appointment, investigations, any procedure/operation, or a follow-up with a medical professional for this condition?	◯ Yes	◯ No

If you answered Yes to Q2, you don't need to answer any more questions in this section. Please go to page 15 to complete the rest of the questions.

Q3. Has the growth ever been described as malignant or cancerous? ◯ Yes ◯ No

For the purposes of this question, a history of rodent ulcer or basal cell carcinoma can be disregarded

Q4. Where was/is the growth, cyst, lump or polyp?

On skin	◯ Yes	◯ No
Kidney	◯ Yes	◯ No
Liver	◯ Yes	◯ No
Pancreas	◯ Yes	◯ No
Brain or spine	◯ Yes	◯ No
Lung	◯ Yes	◯ No
Breast	◯ Yes	◯ No
Ovary	◯ Yes	◯ No
Cervix, uterus or endometrium	◯ Yes	◯ No
Testicle	◯ Yes	◯ No
Bowel or rectum	◯ Yes	◯ No
Thyroid	◯ Yes	◯ No
Other	◯ Yes	◯ No

If answer to Q4 was Thyroid, please answer the following question:

Q5. Was your thyroid growth diagnosed as any of the following?

Toxic goitre	◯ Yes	◯ No
Simple goitre	◯ Yes	◯ No
Thyroid nodule or cyst	◯ Yes	◯ No
Don't know or none of these	◯ Yes	◯ No

If growth was located on the testicle, please answer Q6

Q6. Was your testicular lump diagnosed as any of the following?

Hydrocele	◯ Yes	◯ No
Varicocele	◯ Yes	◯ No
Epididymal cyst	◯ Yes	◯ No
Don't know or none of these	◯ Yes	◯ No

Q7. Who have you sought medical advice from for this condition?

GP only	◯ Yes	◯ No
Specialist (with or without GP)	◯ Yes	◯ No
I have not sought medical advice	◯ Yes	◯ No

If your answer to Q7 is not sought medical advice, please answer Q8, Q9 and Q10 – otherwise move to Q11.

Q8. Are you intending to seek the advice of a medical practitioner for this condition? ◯ Yes ◯ No

Q9. When was the growth first discovered (please give approximate date)? [ ]

Q10. Has the growth or lump changed in appearance or have you had any further symptoms? ◯ Yes ◯ No

Q11. Have you been fully discharged with no further follow-ups required? ◯ Yes ◯ No

Q12. Since you sought medical attention for this condition, has the growth or lump changed in appearance or have you had any further symptoms? ◯ Yes ◯ No

Q13. Has the growth, cyst, lump or polyp been diagnosed as any of the following?

Ganglion	◯ Yes	◯ No
Fatty lump (or lipoma)	◯ Yes	◯ No
Nose or nasal polyp	◯ Yes	◯ No
Sebaceous cyst	◯ Yes	◯ No
Skin tag, wart or verruca	◯ Yes	◯ No
Rodent ulcer or Basal Cell Carcinoma (BCC)	◯ Yes	◯ No
Mole, birthmark or freckle	◯ Yes	◯ No
Keratosis	◯ Yes	◯ No
Not sure	◯ Yes	◯ No
None of these	◯ Yes	◯ No

If the location of the growth, lump or mole was on the skin, please answer Q14, Q15 and Q16.

Q14. Have you had five or more moles or skin abnormalities examined or treated, or have you undergone or been advised to undergo mole mapping? ◯ Yes ◯ No

Q15. When were you most recently seen or reviewed about a skin abnormality? [ ]

Q16. Do you have a family history of skin cancer or multiple mole syndrome?

Examples of multiple syndromes are Dysplastic Naevus Syndrome (DNS), Familial Atypical Multiple Mole Melanoma (FAMMM). ◯ Yes ◯ No

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If the answer to Q7 was 'I have not sought medical advice' please answer Q17

Q17. Please describe the growth, cyst or lump in your own words including where it was situated, any symptoms you had, and why you haven't sought any medical advice.

If the answer to Q4 is Other, or Q13 is Not Sure or None of These please answer the following questions:

Q18. Where was the growth situated?

Q19. What was the name of the growth?

Q20. When was the growth first discovered?

Q21. What treatment did you receive for the growth?

Q22. Please describe this condition in your own words including details of any treatment, follow ups or investigations.

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Heartburn

(Dyspepsia, acid reflux, indigestion, stomach acid, gastric reflux)

Q1. Are you due to see a hospital specialist, to have any investigations, or are you waiting for the results of any investigations?

◯ Yes ◯ No

Q2. Are your symptoms caused by or associated with any of the following?

Ulcer	◯ Yes	◯ No
Barrett's oesophagus	◯ Yes	◯ No
Oesophageal stricture or obstruction	◯ Yes	◯ No
Hiatus hernia	◯ Yes	◯ No
More than one of these conditions	◯ Yes	◯ No
Medication I'm taking for another condition	◯ Yes	◯ No
No related conditions	◯ Yes	◯ No

If you answered yes to ulcer, Barret's oesophagus, oesophageal stricture or obstruction, hiatus hernia or more than one of these conditions you do not need to complete anymore questions in this section

Q3. Have you sought medical advice for your symptoms?

Yes	◯ Yes	◯ No
No	◯ Yes	◯ No
Not yet, but I intend to seek advice	◯ Yes	◯ No

Q4. When did you first have symptoms?

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Q5. Do any of the following apply to your symptoms in the last 12 months? Please select all that apply.

They've got worse, changed or increased in frequency	◯ Yes	◯ No
I have symptoms on most days	◯ Yes	◯ No
I've lost weight without dieting or increasing my exercise	◯ Yes	◯ No
I've had difficulty swallowing food or had choking episodes	◯ Yes	◯ No
I've vomited blood	◯ Yes	◯ No
None of these	◯ Yes	◯ No

Q6. How many days have you taken off work because of this condition in the last 12 months?

If the answer for this question is more than 0, please answer the following question:

Q7. Please provide full details about your condition, how this is managed and how it affects you. We'd like to use your insight to help us understand your condition.

Q8. Have you seen a hospital specialist or had investigations in the last 12 months? ◯ Yes ◯ No

If the answer to Q8 is Have seen a hospital specialist or had investigations in the last 12 months, please answer the following:

Q9. What was the outcome of your investigations or specialist appointment?

I remain under review with a specialist	◯ Yes	◯ No
Investigations were normal and I have been discharged from follow up	◯ Yes	◯ No

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If answer to Q2 is Another condition, please answer the following questions:

Q10. Please describe your symptoms including the severity, frequency, how long they lasted, and whether they continue.

Q11. Please tell us the name of the condition

Q12. When did you last have symptoms of this condition?

Q13. Please provide full details about your condition, how this is managed and how it affects you. We'd like to use your insight to help us understand your condition.

Heart disease

(Ischaemic heart disease, angina, heart attack, coronary heart disease)

Q1. When were you first diagnosed with this condition?

Q2. Have you ever been diagnosed with any of the following?

Atrial flutter or atrial fibrillation	◯ Yes	◯ No
Diabetes or raised blood sugar levels	◯ Yes	◯ No
A stroke, cerebral haemorrhage or TIA (transient ischaemic attack)	◯ Yes	◯ No
Peripheral vascular disease or intermittent claudication	◯ Yes	◯ No
None of the above	◯ Yes	◯ No

Q3. Have you had a heart attack?

One heart attack	◯ Yes	◯ No
More than one heart attack	◯ Yes	◯ No
No, never had a heart attack	◯ Yes	◯ No
Don't know	◯ Yes	◯ No

Q4. Have you had an operation for this condition? ◯ Yes ◯ No

If the answer to Q4 is yes, please answer Q5 and Q6. If no, skip to Q7.

Q5. How many operations have you had?

One	◯ Yes	◯ No
More than one	◯ Yes	◯ No

Q6. What was the date of your operation?

Q7. Please advise how many vessels have been treated/affected.

More than two vessels	◯ Yes	◯ No
One or two vessels	◯ Yes	◯ No
Don't know	◯ Yes	◯ No

Q8. In the last 12 months have you had?

Chest pain, tiredness or palpitations when resting	◯ Yes	◯ No
Chest pain, tiredness or palpitations with normal activity. Normal activity is defined as walking/climbing the stairs at a steady pace	◯ Yes	◯ No
Chest pain, tiredness or palpitations with physical activity such as walking uphill or when walking/climbing the stairs at a rapid pace	◯ Yes	◯ No
Occasional chest pain with no limitations on normal activity such as walking uphill or when walking/climbing the stairs at a rapid pace	◯ Yes	◯ No
No symptoms within the last 12 months	◯ Yes	◯ No

Q9. When did you last see your GP or a specialist for this condition (including routine reviews)?

Q10. Are you awaiting specialist investigations or an operation for this condition? ◯ Yes ◯ No

High cholesterol

(Raised cholesterol, raised lipids)

Q1. Apart from your regular check-ups for cholesterol, are you waiting for any of the following?

Hospital referral	◯ Yes	◯ No
Tests or investigations, or results of these	◯ Yes	◯ No
Neither of these	◯ Yes	◯ No

Q2. Do any of the following apply to you?
Please tick all that apply.

I've been referred or advised to attend a specialist for my cholesterol in the last 5 years	◯ Yes	◯ No
I've been diagnosed with familial high cholesterol or pure hypercholesterolaemia	◯ Yes	◯ No
None of these	◯ Yes	◯ No

Q3. At your last check up, what did the medical professional tell you about your cholesterol? If you know your last cholesterol result and it was over 7, please answer as 'It was high'

It was normal	◯ Yes	◯ No
It was high	◯ Yes	◯ No
Don't know	◯ Yes	◯ No

Q4. Are you taking medication for your cholesterol? ◯ Yes ◯ No

Q5. Have you had your cholesterol tested in the last 12 months? ◯ Yes ◯ No

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If your smoker status is smoker

Q6. On average, how many cigarettes do you smoke per day?

If you answered 'No' to Q4 and Q5, please answer Q7

Q7. Please tell us when your last cholesterol test was, the result (if known), how often you're checked, and what was discussed and advised at your last check. Please also include whether you've been advised to take medication in the past and if so, the reason why you stopped.

Hypertension

(High blood pressure, raised blood pressure, blood pressure, B.P)

Q1. Apart from your regular check-ups for blood pressure, are you waiting for any of the following?

Hospital referral	◯ Yes	◯ No
Tests or investigations, or results of these	◯ Yes	◯ No
Neither of these	◯ Yes	◯ No

If the answer to Q1 is hospital referral or tests or investigations, then there is no need to answer the remaining questions in this hypertension section.

If your smoker status is smoker please answer Q2 below:

Q2. On average, how many cigarettes do you smoke per day? ☐

Q3. Are you taking prescription medication to treat your blood pressure? ◯ Yes ◯ No

If you're currently on treatment, please answer Q4 and Q5, otherwise skip to Q6.

Q4. Have you been told to do any of the following with your blood pressure medication in the last 12 months?

Take it more regularly	◯ Yes	◯ No
Increase medication or change to a different type	◯ Yes	◯ No
No change or reduce medication	◯ Yes	◯ No

Q5. Your surgery will have asked you to have your blood pressure checked at regular intervals. Has yours been checked within the last year?

◯ Yes ◯ No

Please only answer the remaining questions for Hypertension if you selected 'no' on Q3

Q6. Please tell us why prescription medication wasn't needed from the following options:

No medication was needed or advised	◯ Yes	◯ No
Medication was advised but I prefer not to take it	◯ Yes	◯ No
My blood pressure is being reviewed to decide if I need medication	◯ Yes	◯ No

Q7. When was your blood pressure last checked by a medical professional?

Within the last 12 months	◯
13 to 18 months ago	◯
More than 18 months ago	◯

Q8. When your blood pressure was last checked when were you told to have it checked again? Please select the closest match.

Come back in 1, 2, 3 or 4 months from the date of that appointment	◯
A longer period or no follow up checks needed	◯

Q9. When your blood pressure was last checked, was it confirmed to be normal? ◯ Yes ◯ No

Q10. Please tell us about your raised blood pressure, including the cause, the results of any investigations, when it was diagnosed and any blood pressure readings that you may have including the dates these were taken.

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Musculo-skeletal injuries

(Shoulder injury or pain, broken ankle, arm wrist or leg, dislocated or frozen shoulder, fractured wrist, arm or leg)

Q1. Please choose the site of the musculo-skeletal injury from the following:

Shoulders	◯ Yes	◯ No
Arms, wrists or hands	◯ Yes	◯ No
Knees	◯ Yes	◯ No
Legs, ankles or feet	◯ Yes	◯ No
Ribs	◯ Yes	◯ No
Jaw	◯ Yes	◯ No
Back or neck	◯ Yes	◯ No
Hips/pelvis	◯ Yes	◯ No

Q2. Was the injury due to, or complicated by, a medical condition such as osteoporosis? ◯ Yes ◯ No

If the answer to Q2 is Yes please tell us the name of the underlying condition:

Q3. Is an operation planned? ◯ Yes ◯ No

Q4. How much time have you had off work with this?

Q5. Have you fully recovered from this condition? ◯ Yes ◯ No

If you haven't fully recovered from this condition, please answer the following questions:

Q6. Please describe your symptoms including exactly which part(s) of your body is affected by the problem

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Q7. What treatment do you take or undergo?
(Please include prescription medication and physical treatment for example chiropractic or physiotherapy)

If your injury was due to a fracture, please answer the following questions:

Q8. Was your fracture in the last 12 months? ◯ Yes ◯ No

Q9. Have you returned to work (or normal daily activities if not working) with no restrictions of your duties or physical activities? ◯ Yes ◯ No

Q10. Please tell us the exact location of the fracture

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