DATA CAPTURE FORM

BRITISH FRIENDLY

It feels good to be covered

DATA CAPTURE FORM

ABOUT THIS FORM: PLEASE READ CAREFULLY

The Data Capture Form is an adviser tool ONLY for the purpose of recording your clients' information in order to complete our online application. This document does not replace our application and will not be accepted if it is submitted.

PLEASE NOTE

This form ONLY covers our standard application options which include the telephone interview or the online medical and lifestyle questionnaire. If your client wishes to complete a telephone interview instead of the online medical and lifestyle questionnaire, you will only need to complete Section 1 and the Direct Debit Mandate on this form (print pages 1-7). Otherwise, the entire form should be completed.

IMPORTANT INFORMATION: PLEASE READ CAREFULLY

- You are applying for an income protection policy and the answers provided in this application form are your responsibility. It is important that you take reasonable care to answer the questions honestly and to the best of your knowledge; failure to do so may result in your policy being cancelled, the terms of your policy being amended, your claim rejected or not fully paid. If you are unsure whether or not any details are relevant, you should include them or you may wish to consult your doctor before completing the application.
- If there are any changes to your health or other circumstances prior to your policy starting, please inform us immediately. These include a change in occupation, earnings, employment status, travel or residence, the taking up of a hazardous pastime, a change in your own health or that of your father, mother and/or siblings (including half-siblings), and changes to your alcohol consumption and/or smoking habits.
- **Long Term Protect and Short Term Protect Policy only** - The Society will only cover you for benefit payments up to 70% of annual taxable income in the 12 months prior to your incapacity (The Maximum Benefit Level). Therefore, in the event of a claim, the Society will only make benefit payments up to the Maximum Benefit Level, regardless of the amount of benefit payments which you have asked for under the Policy. In the event of a claim you will be asked to provide evidence of your income in the 12 months immediately prior to your incapacity. Failure to provide such evidence will result in your claim not being paid. When assessing your benefit, we will also take into account any continuing payments from your employment or business such as sick pay, payments from other insurance policies and any other sources of income. State benefits will be taken into account if a claim extends beyond 12 months.
- **Breathing Space Policy only** - the Society will cover you for benefit payments as stated in your policy schedule. In the event of a claim, whilst we do not require evidence of your earnings, we will require evidence that you are in active employment at the time of the illness or injury. If you are self-employed we will require your latest HM Revenue & Customs Self-Assessment Tax calculation to ensure your business is still active and producing an income. We do not need to check the level of income produced.
- Most occupations will be considered with the exception of those occupations that are excluded from cover. The list of excluded occupations is contained in the Eligibility section. This list was up to date at the time of issue. The list will be reviewed by the Society from time to time. For an up-to date list of excluded occupations please visit our website: www.britishfriendly.com or contact our Underwriting Department.
- The Society reserves the right to apply special terms or higher premiums or postpone or decline any application.
- Please note that no cover is effective until your policy starts. We also recommend that any existing cover is not cancelled until your policy starts and you are satisfied that it meets your needs.

I confirm that I have read and understood the above statements:

Yes ☐

BENEFIT REQUIRED

You may select either a Long Term Protect or Short Term Protect policy or a Breathing Space policy.

Long Term Protect
This option provides benefit payments on an on-going basis in the event of incapacity until your chosen retirement age.

Short Term Protect
This option provides benefit payments for periods of up to 1, 2 or 5 years in the event of incapacity.

Breathing Space
This option provides benefit payments for periods of up to 1, 2 or 5 years in the event of incapacity. This option does not require us to check the level of income produced.

IMPORTANT NOTE FOR BREATHING SPACE

The Society will cover you for the benefit payments as stated in your Policy Schedule. In the event of a claim, whilst we do not require evidence of your earnings, we will require evidence that you are in active employment at the time of the illness or injury. If you are self-employed we will require your latest HM Revenue and Customs Self-Assessment Tax Calculation to ensure your business is still active and producing an income. We do not need to check the level of income produced.

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YOUR PERSONAL DETAILS

Date of Birth: _____ DD/MM/YYYY

Title (Mr/Mrs/Miss/Ms/Dr/Prof): _____

First Name(s): _____

Last Name: _____

Gender: Male ☐ Female ☐

YOUR CONTACT DETAILS

During the application process one of our partner companies or underwriters may need to contact you to obtain medical/ lifestyle information or discuss the application. Please provide your preferred contact details.

Telephone Numbers: Home: _____ Work: _____ Mobile: _____

Home Address: _____

_____

Postcode: _____

Email address: _____

INCOME PROTECTION WITH BRITISH FRIENDLY

We take protecting your data very seriously and therefore it is important you read our Privacy Policy which can be found on our website. This policy explains how we process 'special category' information (which includes medical and genetic information e.g. BMI). Please understand that processing of personal data is necessary for the Society to offer you this Policy and that if you refuse consent or later withdraw consent the application will have to be cancelled. Should you have any concerns, or decide not to proceed with your cover, you have a 30 day cooling off period in which to cancel your policy.

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YOUR OCCUPATIONAL DETAILS

The information provided in this form helps us assess if you are eligible for this policy. It is important that you take reasonable care to answer the questions honestly and to the best of your knowledge.

1. Have you been resident in the UK for the last 3 years and is your income liable to UK tax? Yes ☐ No ☐
   If you have answered 'No' to the above question we will not be able to accept your application.
2. Do you have a UK Bank or Building society account? Yes ☐ No ☐
   If you have answered 'No' to the above question we will not be able to accept your application.
3. Does any part of your paid or unpaid occupation(s) include any of the following? Yes ☐ No ☐
   - Armed Forces Personnel including members of a Military Reserve Force
   - Handling explosives
   - Merchant Navy including members of the Royal Naval Reserves
   - Divers
   - Underground Miners
   - Oil Rig Workers
   - Professional or Semi-Professional Sports Persons
   - Nightclub Security Personnel or Bodyguards
   - Equestrian Professions
   - Police Officers including Police Community Support Officers and Special Constables
   - Fire-fighters including reserve or retained Fire-fighters

   If you have answered 'Yes' to the above question we will not be able to accept your application.

YOUR EMPLOYMENT

Job Title: _____

Employment Status: Employed ☐ Self-employed ☐ In Partnership ☐ Director/Company ☐ Other ☐

Roughly how much manual/physical labour do you undertake as part of your occupation?

None ☐ Less than half ☐ About half ☐ More than half ☐ All ☐

YOUR EARNINGS (LONG TERM PROTECT AND SHORT TERM PROTECT ONLY)

If you need to make a claim we will require proof of your earnings in the previous 12 months. If you are unable to provide evidence that supports the earnings stated the claim benefit you receive may be affected.

Occupational Status	Earnings	Dividends	Total Earnings	Evidence required to make a valid claim
Employed (indicate your gross annual salary)		N/A		Printed pay slips, P60 and P11d if applicable
Self-employed/In-partnership (indicate your taxable profit)		N/A		Most recent business accounts, tax return and agreed HMRC tax assessment
Director/Shareholder in a private limited company (indicate your gross annual salary plus any regular dividends you received from the company over the last 12 months)				Printed pay slips, P60 and P11d if applicable plus regular dividend vouchers
		Total	£	

In the event of a claim are you able to provide evidence of your stated earnings? Yes ☐ No ☐
If you have answered 'No' to the above question we will not be able to accept your application.

If you are unable to work due to sickness or injury would you continue to receive any earnings/income? Yes ☐ No ☐

If 'Yes', what earnings will you continue to receive during a period of sickness or injury?

Amount £_____ Frequency _____ For how long _____

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YOUR MEDICAL DETAILS

1. Have you ever made an application to British Friendly Society that has been postponed, declined, offered on special terms or cancelled?

   ☐ Yes ☐ No

2. Have you been registered with a UK GP for at least 3 consecutive years and does your current UK GP have access to your medical records for at least the last 3 years? Yes ☐ No ☐

   If you have answered 'No' to the above question we will not be able to accept your application.

3. Do any of the following statements apply to you? Yes ☐ No ☐

   - I am currently unable to work or working reduced hours or on restricted duties due to sickness or accident
   - I have suffered from symptoms of chronic fatigue syndrome, ME or fibromyalgia in the last 2 years
   - I have suffered from cancer or malignant tumour which has been treated with radiotherapy or chemotherapy in the last 3 years
   - I am currently suffering from an illness for which I am being prescribed methotrexate or immunosuppressive treatment
   - I have used heroin, opiates or other drugs intravenously within the last 5 years
   - I have had a stroke or mini stroke (also known as transient ischaemic attack)
   - I have had a heart attack
   - I have suffered from or been diagnosed with angina or coronary heart disease
   - I have suffered from or been diagnosed with multiple sclerosis
   - I have been diagnosed with Parkinson's disease
   - I have been diagnosed with Alzheimer's disease or dementia
   - I am suffering from paralysis, paraplegia or quadriplegia caused by damage to my spinal cord
   - I have suffered from or been diagnosed with insulin-dependent diabetes (other than during pregnancy)
   - I have been diagnosed with HIV or I am awaiting the results of a HIV test
   - I have undergone a major organ transplant

   If you have answered ‚Yes' to any of the above statements, we will not be able to accept your application.

4. Have you ever been referred to or seen a psychiatrist or psychologist?

   Yes ☐ No ☐

BMI

1. What is your height?		**feet**		**inches**	**or**		**cm**
2. What is your weight?		**stone**		**lbs**	**or**		**kg**

POLICY START DATE

We want to make sure that you have the cover you need as soon as possible. Therefore it is our practice to start your policy at the earliest opportunity. If this is not suitable please let us know a specific date you want the policy to start or whether you would like to tell us at a later date.

Whatever option you choose, there may be a period of time between submitting the application and the policy start date. Please notify us immediately if there are any changes to your health or other circumstances during this period. "Other circumstances" include taking up a hazardous pastime or changes in:

- Your occupation
- Your earnings
- Your employment status
- Travel or residence
- The health of your father, mother or siblings (including half siblings)
- Your alcohol consumption or smoking habits

Please note that any changes could result in a change or premium or the addition of an exclusion to your policy.

When would you like your policy to start?

At the earliest possible date: Yes ☐ Set a date: ☐ DD/MM/YYYY

Date to be confirmed: Yes ☐

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APPLICANT'S DATE OF BIRTH

☐ DD/MM/YYYY

BENEFIT TYPE: LONG TERM PROTECT

Weekly benefit required: _____

Monthly benefit required: _____

Your age when policy should cease: _____

Deferred period: Day one ☐ 1 week ☐ 4 weeks ☐ 8 weeks ☐

13 weeks ☐ 26 weeks ☐ 52 weeks ☐

Should the cover selected increase in line with RPI? Yes ☐ No ☐

Claim length: **Until retirement**

Has your adviser given you financial advice? Yes ☐ No ☐

BENEFIT TYPE: SHORT TERM PROTECT

Weekly benefit required: _____

Monthly benefit required: _____

Your age when policy should cease: _____

Deferred period: 1 week ☐ 4 weeks ☐ 8 weeks ☐ 13 weeks ☐

Should the cover selected increase in line with RPI? Yes ☐ No ☐

In the event of an illness how long would you like your sickness benefit to be paid for after your deferred period has elapsed?

1 year ☐ 2 years ☐ 5 years ☐

Has your adviser given you financial advice? Yes ☐ No ☐

BENEFIT TYPE: BREATHING SPACE

Weekly benefit required: _____

Monthly benefit required: _____

Your age when policy should cease: _____

Deferred period: 1 week ☐ 4 weeks ☐ 8 weeks ☐ 13 weeks ☐

Should the cover selected increase in line with RPI? ☐ Yes ☐ No

In the event of an illness how long would you like your sickness benefit to be paid for after your deferred period has elapsed?

☐ 1 year ☐ 2 years ☐ 5 years

Has your adviser given you financial advice? Yes ☐ No ☐

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DIRECT DEBIT MANDATE

Please fill in the whole form using a ball point pen and send it to:
British Friendly Society Limited
45 Bromham Road
Bedford, MK40 2AA

Telephone:
01234 358344

Fax:
01234 327879

British Friendly only accepts Direct Debit as the method of payment for premiums. Advance notification of the first premium collection date and amount will be sent out with your policy documentation.

On which day of the month does your client want their premiums to be collected?

1st ☐ 15th ☐

YOUR BANK DETAILS

Name and full postal address of your Bank or Building Society

To: The Manager
Bank/Building Society
Address:
Postcode

Account name:

Account number:

Bank sort code:

Instruction to your Bank or Building Society to pay by Direct Debit

Service user number

6	9	8	0	1	4

Reference

FOR THE BRITISH FRIENDLY SOCIETY LTD OFFICIAL USE ONLY
This is not part of the instruction to your bank or building society

Instruction to your Bank or Building Society

Please pay British Friendly Society Ltd Direct Debits from the account detailed in this instruction, subject to the safeguards assured by the Direct Debit Guarantee. I understand that this instruction may remain with British Friendly Society Ltd and if so, will be passed electronically to my Bank/Building Society.

Signature (s)
Date

This Guarantee should be detached and retained by the payer.

THE DIRECT DEBIT GUARANTEE

- This Guarantee is offered by all banks and building societies that accept instructions to pay Direct Debits.
- If there are any changes to the amount, date or frequency of your Direct Debit the British Friendly Society Ltd will notify you three working days in advance of your account being debited or as otherwise agreed. If you request the British Friendly Society Ltd to collect a payment, confirmation of the amount and date will be given to you at the time of the request.
- If an error is made in the payment of your Direct Debit, by the British Friendly Society Ltd or your bank or building society you are entitled to a full and immediate refund of the amount paid from your bank or building society.
- If you receive a refund you are not entitled to, you must pay it back when the British Friendly Society Ltd asks you to.
- You can cancel a Direct Debit at any time by simply contacting your bank or building society. Written confirmation may be required. Please also notify us.

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DECLARATION AND CONSENT

Please read the following statements and confirm you understand and agree with them before submitting this application.

- I understand the important information section of this form.
- I have been provided with a copy of the full Policy Terms and Conditions as this will form the basis of my contract with British Friendly.
- These documents form part of our standard Client agreement upon which we intend to rely. If you do not understand any points raised in these materials, please ask for further information.
- I accept full responsibility for the accuracy of the answers and statements given, even if they were recorded on my behalf, and confirm that they are true and complete to the best of my knowledge and belief. I further agree that if I have knowingly made any incorrect statement in this, my application, the rules of the Society will be strictly applied and my entitlement to all benefits will cease.
- I understand that the Society will underwrite my application based on the information I have provided on this form and either during the telephone interview or on the medical questionnaire form and I will not assume that the Society will automatically obtain a medical report or confirm or clarify the information provided.
- I shall advise the Society of any changes in my health and other circumstances which happen before the policy starts. I consent to the Society storing and using my personal information (including any medical information) for the purposes set out above in our Data Protection Statement.

Answer yes or no to the following statements

- I understand and agree to the above declarations — Yes ☐ No ☐
- If any Doctors report is requested I wish to see a copy before it is sent to the Society — Yes ☐ No ☐
- I wish to receive marketing information — Yes ☐ No ☐

By opting to receive marketing information, you can stay informed about new products, services and special offers by British Friendly.

ADVICE AND COMMISSION

Has your adviser given you financial advice about this policy? Yes ☐ No ☐

Commission required: Indemnity ☐ Non-indemnity ☐ Non-standard ☐

Please continue on to Section 2 if you wish to complete the online medical and lifestyle questionnaire option.

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SECTION 2 - TRAVEL

2.1 Do you intend to live, work or travel outside the UK (other than for holidays) or have you done so in the past five years? Yes ☐ No ☐

If 'Yes', please go to 'Details of Travel': If 'No', please go to Section 3, 'Sports and Hobbies'.

2.1.1 DETAILS OF TRAVEL 1

Where:						
From: (mm/yyyy)						
To: (mm/yyyy)						
Duration in weeks?	<2 weeks ☐	2-4 weeks ☐	4-12 weeks ☐	12-26 weeks ☐	26-52 weeks ☐	>52 weeks ☐
Reason for visit	Work purposes ☐	Residency ☐	Volunteering ☐	Career break /gap year ☐	Other ☐	

2.1.2 DETAILS OF TRAVEL 2

Where:						
From: (mm/yyyy)						
To: (mm/yyyy)						
Duration in weeks?	<2 weeks ☐	2-4 weeks ☐	4-12 weeks ☐	12-26 weeks ☐	26-52 weeks ☐	>52 weeks ☐
Reason for visit	Work purposes ☐	Residency ☐	Volunteering ☐	Career break /gap year ☐	Other ☐	

2.1.3 DETAILS OF TRAVEL 3

Where:						
From: (mm/yyyy)						
To: (mm/yyyy)						
Duration in weeks?	<2 weeks ☐	2-4 weeks ☐	4-12 weeks ☐	12-26 weeks ☐	26-52 weeks ☐	>52 weeks ☐
Reason for visit	Work purposes ☐	Residency ☐	Volunteering ☐	Career break /gap year ☐	Other ☐	

If there is insufficient space to tell us about all your travel details, please continue on the 'Additional Information' section on page 54.

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SECTION 3 - SPORTS AND HOBBIES

3.1. Do you currently, or do you intend to, take part in any sports or hobbies which could lead to an increased risk of injury? ☐ Yes ☐ No

3.2. If Yes, please indicate which if any of these activities you currently participate in or have plans to participate in:

If No, go to Section 4.

☐ **Adventure Racing** Sprint, Endurance and 24 hour events only	☐ **Adventure Racing** Multiday, Expedition events	☐ **Ballooning** more than 50 flight hours per year
☐ **Base Jumping**	☐ **Boxing** amateur/contact	☐ **Bungee Jumping** more than 5 jumps in total
☐ **Cycling** amateur participation in competitions	☐ **Diving Sports** All other types of sub aqua diving at depths below 40 metres and any high diving activities	☐ **Equestrian Sports** Flat Racing, Steeplechase or National Hunt, Racing Harness Racing, Carriage Driving, Hunting, Polo, Point to Point, Rodeo, Show-jumping, Three-day Eventing
☐ **Gliding** Non-powered	☐ **Hand Gliding** Powered and Non-powered	☐ **Hunting - Big Game Hunting** Regular/Trophy Seeker
☐ **Martial Arts** (apart from Aikido, Hapkido and Judo)	☐ **Martial Arts** (Aikido, Hapkido and Judo)	☐ **Microlighting**
☐ **Motor Sport**	☐ **Motor Cycle Sport**	☐ **Mountaineering & Climbing** (apart from Trekking, Bouldering, Hillwalking, Artificial Climbing Wall and Coasteering)
☐ **Mountain Biking**	☐ **Parachuting** more than 10 jumps a year	☐ **Paragliding/Parascending** Record attempts/test flying/ competition flying
☐ **Potholing & Caving**	☐ **Powerboat Racing**	☐ **Private Aviation** Competition, test or experimental flying, stunt flying, aeronautics, aerobatics, air-racing or air rallying
☐ **Quad Biking**	☐ **Rugby**	☐ **Sailing/Yachting** Racing or Ocean Sailing
☐ **War Gaming**	☐ **Water Sports** White water rafting, more active participation, competitions, instructor level	☐ **Winter Sports** Bobsleigh, Heli-Skiing , Ice Boating, Ice Hockey, Luge Tobogganing, Ski Bob, Off-Piste Skiing, Ski Jumping, Snowboarding (Off-Piste) participation in snowmobiling competitions - competitive racing (i.e snow cross)
☐ **Weight Lifting/Body Building** Recreational - for fitness/ training purposes only	☐ **Weight Lifting/Body Building** Competitive, amateur	☐ **Wrestling** for fitness/training purposes only
☐ **Wrestling** amateur	☐ **Zorbing** Instructor level, more than 10 times per year	☐ **None of the above**

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SECTION 4 - LIFESTYLE

4.1. Have you smoked or used nicotine replacement products or e-cigarettes in the last 12 months? (We may ask for a simple medical test to confirm this) Yes ☐ No ☐

If 'Yes', please go to 'Nicotine Consumption': If 'No', please go to question 4.2.

NICOTINE CONSUMPTION

4.1.1. Please state your typical consumption:

Cigarettes	Small Cigars	Medium Cigars	Large Cigars	Rolled Tobacco
☐ 1-10 per day	☐ 1-10 per day	☐ 1-10 per day	☐ 1-10 per day	☐ 25 g (1oz) per week
☐ 11-20 per day	☐ 11-20 per day	☐ 11-20 per day	☐ Over 10 per day	☐ 50 g (2oz) per week
☐ 21-30 per day	☐ 21-30 per day	☐ 21-25 per day		☐ 75 g (3oz) per week
☐ 31-40 per day	☐ 31-40 per day	☐ Over 25 per day		☐ 100 g (4oz) per week
☐ 41-50 per day	☐ 41-50 per day			☐ 125 g (5oz) per week
☐ Over 50 per day	☐ Over 50 per day			☐ 150 g (6oz) per week
				☐ 175 g (7oz) per week
				☐ Other

If you have answered 'Other' to rolled tobacco, please tell us what your typical weekly consumption is?_____

If you use, or have used any other type of nicotine product, including nicotine replacement therapy or e-cigarettes in the last 12 months, please tell us what you use, or have used, and your typical weekly consumption?

Nicotine Product 1:

Type of nicotine product? _____

Typical weekly consumption? _____

Nicotine Product 2:

Type of nicotine product? _____

Typical weekly consumption? _____

Nicotine Product 3:

Type of nicotine product? _____

Typical weekly consumption? _____

DATA CAPTURE FORM

SECTION 4 - LIFESTYLE (CONTINUED)

4.2. Do you drink alcohol? Yes ☐ No ☐

If 'Yes', please go to 'Alcohol Consumption': If 'No', please go to question 4.4.

ALCOHOL CONSUMPTION

4.2.1. How many units of alcohol do you drink a week?
1 glass of wine (175 ml) = 2 units, 1 pint of standard lager/beer = 2 units, 1 measure spirits (25ml) = 1 unit

- ☐ 1-14 units per week
- ☐ 15-29 units per week
- ☐ 30-44 units per week
- ☐ 45-50 units per week
- ☐ Over 50 units per week

4.3. Have you ever been advised by your doctor or other health professional to drink less alcohol? Yes ☐ No ☐

If 'Yes', please go to 'Alcohol Advice': If 'No', please go to question 4.4.

ALCOHOL ADVICE

4.3.1. Why was this? _____

4.3.2. When was this?

- ☐ Under 12 months ago
- ☐ 1 to 2 years ago
- ☐ 2 to 3 years ago
- ☐ 3 to 4 years ago
- ☐ 4 to 5 years ago
- ☐ Over 5 years ago

4.3.3. Have you now reduced the amount of alcohol you drink? Yes ☐ No ☐

If 'Yes', please go to question 4.4.4: If 'No', please go to question 4.5.

4.3.4. How much alcohol were you drinking at the time? (units per week)

- ☐ 1-10 units per week
- ☐ 11-20 units per week
- ☐ 21-30 units per week
- ☐ 31-40 units per week
- ☐ 41-50 units per week
- ☐ Over 50 units per week

4.3.5. How long did you drink this amount of alcohol for?

- ☐ Under 12 months
- ☐ 1 to 2 years
- ☐ 2 to 3 years
- ☐ 3 to 4 years
- ☐ 4 to 5 years
- ☐ Over 5 years

4.4. Have you ever used recreational drugs?
(e.g. ecstasy, cocaine, heroin, cannabis, anabolic steroids, etc.) Yes ☐ No ☐

If 'Yes', please go to 'Drug Use': If 'No', please go to question 4.6.

DRUG USE

4.4.1. Type of drug used?

Drug 1

Cannabis ☐ Cocaine ☐ Ecstasy ☐ LSD ☐ Hallucinogens such as psychedelic mushrooms ☐
Barbiturates ☐ Sedatives ☐ Solvents ☐ Opium ☐ Amphetamines ☐ Heroin ☐ Other ☐

Drug 2

Cannabis ☐ Cocaine ☐ Ecstasy ☐ LSD ☐ Hallucinogens such as psychedelic mushrooms ☐
Barbiturates ☐ Sedatives ☐ Solvents ☐ Opium ☐ Amphetamines ☐ Heroin ☐ Other ☐

Drug 3

Cannabis ☐ Cocaine ☐ Ecstasy ☐ LSD ☐ Hallucinogens such as psychedelic mushrooms ☐
Barbiturates ☐ Sedatives ☐ Solvents ☐ Opium ☐ Amphetamines ☐ Heroin ☐ Other ☐

SECTION 4 - LIFESTYLE (CONTINUED)

4.4.1.1. If you have answered 'Other' to question 4.4.1., please tell us about the type(s) of recreational drug you use or have used in the past?

Drug 1: _____

Drug 2: _____

Drug 3: _____

4.5 How did you take this drug i.e. injected, smoked, swallowed etc.?

Drug 1:	☐ Intravenously i.e. injected	☐ Non-intravenously i.e. smoked, swallowed as pill etc.
Drug 2:	☐ Intravenously i.e. injected	☐ Non-intravenously i.e. smoked, swallowed as pill etc.
Drug 3:	☐ Intravenously i.e. injected	☐ Non-intravenously i.e. smoked, swallowed as pill etc.

4.5.1 When did you first start to use this drug?

Drug 1:	MM/YYYY	_____	☐ I don't know
Drug 2:	MM/YYYY	_____	☐ I don't know
Drug 3:	MM/YYYY	_____	☐ I don't know

4.5.2. How long did you use this drug for or are you still using it?

Drug 1:	☐ Current use	☐ Under 12 months	☐ 2-3 years	☐ 4-5 years
	☐ One off use only	☐ 1-2 years	☐ 3-4 years	☐ Over 5 years
Drug 2:	☐ Current use	☐ Under 12 months	☐ 2-3 years	☐ 4-5 years
	☐ One off use only	☐ 1-2 years	☐ 3-4 years	☐ Over 5 years
Drug 3:	☐ Current use	☐ Under 12 months	☐ 2-3 years	☐ 4-5 years
	☐ One off use only	☐ 1-2 years	☐ 3-4 years	☐ Over 5 years

4.5.3. When did you last use this drug?

Drug 1:	☐ Current use	☐ Under 12 months	☐ 2-3 years	☐ 4-5 years
	☐ One off use only	☐ 1-2 years	☐ 3-4 years	☐ Over 5 years
Drug 2:	☐ Current use	☐ Under 12 months	☐ 2-3 years	☐ 4-5 years
	☐ One off use only	☐ 1-2 years	☐ 3-4 years	☐ Over 5 years
Drug 3:	☐ Current use	☐ Under 12 months	☐ 2-3 years	☐ 4-5 years
	☐ One off use only	☐ 1-2 years	☐ 3-4 years	☐ Over 5 years

If there is insufficient space to tell us about all the recreational drugs you use or have used in the past, please continue on the 'Additional Information' section on page 54.

SECTION 4 - LIFESTYLE (CONTINUED)

4.6. Have you ever tested positive for Hepatitis B or C or are you awaiting the result of such a test? Yes ☐ No ☐

If 'Yes', please go to question 4.6.1: If 'No', go to Section 5, 'General Health'.

4.6.1. What condition has been diagnosed?

☐ Hepatitis B – **Go to question 4.6.2**

☐ Hepatitis C – **Go to question 4.6.2**

☐ Awaiting results of test – **Go to Hepatitis Results**

4.6.2. Are you currently having treatment? Yes ☐ No ☐

If 'Yes', please go to 'Hepatitis Treatment': If 'No', go to Section 5, 'General Health'.

HEPATITIS TREATMENT

4.6.2.1. Please tell us about the type of treatment you are currently receiving, including the dosage or frequency of the treatment?

Treatment 1:

Type of treatment? _____

Dosage or frequency? _____

Treatment 2:

Type of treatment? _____

Dosage or frequency? _____

Treatment 3:

Type of treatment? _____

Dosage or frequency? _____

If there is insufficient space to tell us about all the treatments you have received, please continue on the 'Additional Information' section on page 54.

HEPATITIS RESULTS

4.6.3. When was the test carried out? MM/YYYY _____ I don't know ☐

4.6.4. When are your results due? MM/YYYY _____ I don't know ☐

DATA CAPTURE FORM

SECTION 5 - GENERAL HEALTH

HEART, CIRCULATION AND BLOOD

5.1. Have you ever had any disease or disorder of your heart including irregular heartbeat, palpitations or chest pain? Yes ☐ No ☐
If 'Yes', please go to the 'General Health Questionnaire' - pages 24-41 If 'No', go to question 5.2.

5.2. In the last 5 years have you had high or low blood pressure? Yes ☐ No ☐
If 'Yes', please go to the 'Blood Pressure Questionnaire' - pages 46-49: If 'No', go to question 5.3.

5.3. In the last 5 years have you had raised cholesterol? Yes ☐ No ☐
If 'Yes', please go to the 'Raised Cholesterol Questionnaire' - pages 50-53: If 'No', go to question 5.4.

5.4. In the last 5 years have you had any problems with your circulation, deep vein thrombosis (DVT) or varicose veins? Yes ☐ No ☐
If 'Yes', please go to the 'General Health Questionnaire' - pages 24-41: If 'No', go to question 5.5.

5.5. In the last 5 years have you had any disease or disorder of your blood including anaemia? Yes ☐ No ☐
If 'Yes', please go to the 'General Health Questionnaire' - pages 24-41:
If 'No', male applicants go to question 5.6, female applicants go to question 5.7.

5.6. **Males only** – In the last 5 years have you had any disease or disorder of your male reproductive system, including testicular disorders, prostate enlargement or raised PSA (prostate specific antigen?) Yes ☐ No ☐
If 'Yes', please go to the 'General Health Questionnaire' - pages 24-41: If 'No', go to question 5.7.

BONES, MUSCLES, JOINTS AND LIGAMENTS

5.7. Have you ever had any form of arthritis, rheumatism or gout? Yes ☐ No ☐
If 'Yes', please go to the 'General Health Questionnaire' - pages 24-41: If 'No', go to question 5.8.

5.8. In the last 5 years have you had any disease or disorder of your back or neck, including sciatica, slipped disc or whiplash injury? Yes ☐ No ☐
If 'Yes', please go to the 'General Health Questionnaire' - pages 24-41: If 'No', go to question 5.9.

5.9. In the last 5 years have you had any bone fractures or any disease or disorder of your joints, ligaments, bones or muscles, including any conditions or pain affecting your hips, shoulders, knees, wrists or any other joints? Yes ☐ No ☐
If 'Yes', please go to the 'General Health Questionnaire' - pages 24-41: If 'No', go to question 5.10.

BRAIN AND NERVOUS SYSTEM

5.10. Have you ever had any disease or disorder of your brain or central nervous system, including any form of epilepsy or fits, optic neuritis, cerebral palsy, brain injury or brain haemorrhage? Yes ☐ No ☐
If 'Yes', please go to the 'General Health Questionnaire' - pages 24-41: If 'No', go to question 5.11.

5.11. In the last 5 years have you had any numbness, muscle weakness, changes in skin sensation, tingling, tremor, lack of coordination or difficulty in walking? Yes ☐ No ☐
If 'Yes', please go to the 'General Health Questionnaire' - pages 24-41: If 'No', go to question 5.12.

5.12. In the last 5 years have you had any fainting, blackouts, dizziness, facial pain, migraine or recurrent headaches? Yes ☐ No ☐
If 'Yes', please go to the 'General Health Questionnaire' - pages 24-41: If 'No', go to question 5.13.

MENTAL HEALTH

5.13. Have you ever had any mental illness including depression, stress, anxiety, low mood, eating disorders or insomnia or have you ever been referred to a psychiatrist, psychologist or counsellor? Yes ☐ No ☐
If 'Yes', please go to the 'General Health Questionnaire' - pages 24-41: If 'No', go to question 5.14.

5.14. In the last 5 years have you had chronic fatigue syndrome, ME or Fibromyalgia? Yes ☐ No ☐
If 'Yes', please go to the 'General Health Questionnaire' - pages 24-41: If 'No', go to question 5.15.

DIABETES AND THYROID DISORDERS

5.15. Do you have diabetes or have you had sugar in your urine or gestational diabetes (diabetes of pregnancy)? Yes ☐ No ☐
If 'Yes', please go to the 'Diabetes Questionnaire' - pages 42-45: If 'No', go to question 5.16.

5.16. In the last 5 years have you had any disease or disorder of your thyroid? Yes ☐ No ☐
If 'Yes', please go to the 'General Health Questionnaire' - pages 24-41: If 'No', go to question 5.17.

SECTION 5 - GENERAL HEALTH (CONTINUED)

DIGESTION AND BOWELS

5.17. In the last 5 years have you had any digestive, liver, stomach, pancreas, gallbladder or bowel conditions including hernia, ulcers, hepatitis, colitis or Crohn's disease? Yes ☐ No ☐

If 'Yes', please go to the 'General Health Questionnaire' - pages 24-41: If 'No', go to question 5.18.

KIDNEYS AND BLADDER

5.18. In the last 5 years have you had any kidney, bladder or urinary conditions including blood or protein in your urine or urinary tract infections? Yes ☐ No ☐

If 'Yes', please go to the 'General Health Questionnaire' - pages 24-41: If 'No', go to question 5.19.

CANCERS AND TUMOURS

5.19. Have you ever had any form of cancer, Hodgkin's disease, leukaemia, lymphoma, spinal, brain or bowel tumours (whether malignant or benign)? Yes ☐ No ☐

If 'Yes', please go to the 'General Health Questionnaire' - pages 24-41: If 'No', go to question 5.20.

SKIN DISORDERS

5.20. In the last 5 years have you had any disease or disorder of your skin, including eczema, dermatitis or psoriasis? Yes ☐ No ☐

If 'Yes', please go to the 'General Health Questionnaire' - pages 24-41: If 'No', go to question 5.21.

5.21. In the last 5 years have you had any lump, growth or cyst of any kind, or any mole or freckle that has bled, become painful, changed appearance or increased in size? Yes ☐ No ☐

If 'Yes', please go to the 'General Health Questionnaire' - pages 24-41: If 'No', go to question 5.22.

BREATHING DISORDERS

5.22. In the last 5 years have you had asthma, bronchitis, hay fever or any other lung or breathing problems? Yes ☐ No ☐

If 'Yes', please go to the 'General Health Questionnaire' - pages 24-41: If 'No', go to question 5.23.

EYES AND EARS

5.23. In the last 5 years have you had any disease or disorder of your eyes including blurred or double vision, glaucoma or cataracts? (Any impaired vision fully corrected by glasses or lenses can be ignored). Yes ☐ No ☐

If 'Yes', please go to the 'General Health Questionnaire' - pages 24-41: If 'No', go to question 5.24.

5.24. In the last 5 years have you had any disease or disorder of your ears, including hearing loss, tinnitus or balance problems such as Meniere's disease or labyrinthitis? Yes ☐ No ☐

If 'Yes', please go to the 'General Health Questionnaire' - pages 24-41:
If 'No' female applicants go to question 5.25, male applicants go to Section 6 - Medications and Treatment.

GYNAECOLOGICAL DISORDERS

5.25. **Females only** – In the last 5 years have you had any abnormal cervical smears or mammograms, painful or heavy periods, abnormal bleeding, fertility treatment or any other gynaecological condition requiring treatment, investigation or advice? Yes ☐ No ☐

If 'Yes', please go to the 'General Health Questionnaire' - pages 24-41:

If 'No', go to Section 6, 'Medications and Treatment'.

DATA CAPTURE FORM

SECTION 6 - MEDICATIONS AND TREATMENT

6.1. Are you currently taking any prescribed drugs, medicines or tablets or receiving any other treatment for any medical condition(s) you have not already mentioned in this application? (you do not need to mention contraceptives, HRT or cold/flu remedies) Yes ☐ No ☐
If 'Yes', please go to 'Medication Details': If 'No', go to question 6.2.

MEDICATION DETAILS

6.1.1. Please tell us about the type of medication or treatment you are currently taking or receiving which you have not already mentioned in this application, including the dosage or frequency? Yes ☐ No ☐
If 'Yes', please go to the 'General Health Questionnaire' - pages 24-41: If 'No', go to question 5.16.

Medication/Treatment 1:
Type of medication/treatment? _____
Dosage or frequency? _____

Medication/Treatment 2:
Type of medication/treatment? _____
Dosage or frequency? _____

Medication/Treatment 3:
Type of medication/treatment? _____
Dosage or frequency? _____

6.1.2. When did you start to take or receive this medication or treatment?

Medication/Treatment 1: MM/YYYY _____ I don't know ☐
Medication/Treatment 2: MM/YYYY _____ I don't know ☐
Medication/Treatment 3: MM/YYYY _____ I don't know ☐

6.1.3. Please tell us what you are receiving this medication or treatment for?

Medication/Treatment 1:
Reason for receiving medication/treatment? _____

Medication/Treatment 2:
Reason for receiving medication/treatment? _____

Medication/Treatment 3:
Reason for receiving medication/treatment? _____

6.1.4. When did the medical condition start?

Medication/Treatment 1 start date? MM/YYYY _____ I don't know ☐
Medication/Treatment 2 start date? MM/YYYY _____ I don't know ☐
Medication/Treatment 3 start date? MM/YYYY _____ I don't know ☐

If there is insufficient space to tell us about all the medications or treatments you are currently receiving which you have not already mentioned in this application, please continue on the 'Additional Information' section on page 54.

SECTION 6 - MEDICATIONS AND TREATMENT (CONTINUED)

6.2. Are you currently awaiting a medical consultation or hospital appointment, treatment, test or investigation which you have not already mentioned in this application? Yes ☐ No ☐
If 'Yes', please go to 'Consultation Details': If 'No', go to question 6.3.

CONSULTATION DETAILS

6.2.1. Please tell us about the type(s) of consultation, appointment, treatment, test or investigation are you waiting for?

Consultation 1:
Type of consultation? _____

Consultation 2:
Type of consultation? _____

Consultation 3:
Type of consultation? _____

6.2.2. When is this due or planned for?

Consultation 1: MM/YYYY _____ I don't know ☐

Consultation 2: MM/YYYY _____ I don't know ☐

Consultation 3: MM/YYYY _____ I don't know ☐

If there is insufficient space to tell us about all the medical consultations, hospital appointments, treatment, tests or investigations you are currently awaiting which you have not already mentioned in this application, please continue on the 'Additional Information' section on page 54.

6.3. Are you currently experiencing any symptoms which you have not already mentioned for which you might seek medical attention? Yes ☐ No ☐
If 'Yes', please go to 'Symptom Details': If 'No', go to question 6.4.

SYMPTOM DETAILS

6.3.1. What is the nature of your symptoms?

Symptom 1:
Nature of symptom? _____

Symptom 2:
Nature of symptom? _____

Symptom 3:
Nature of symptom? _____

6.3.2. When did the symptoms start?

Symptom 1: MM/YYYY _____ I don't know ☐

Symptom 2: MM/YYYY _____ I don't know ☐

Symptom 3: MM/YYYY _____ I don't know ☐

If there is insufficient space to tell us about all the symptoms you are currently experiencing which you have not already mentioned in this application for which you might seek medical attention, please continue on the 'Additional Information' section on page 54.

SECTION 6 - MEDICATIONS AND TREATMENT (CONTINUED)

6.4. In the last 5 years have you had, or been advised to have, any medical investigation, test or scan (including blood tests) due to any medical condition(s) you have not already mentioned in this application? Yes ☐ No ☐

If 'Yes', please go to 'Test and Investigation Details': If 'No', go to question 6.5.

TEST AND INVESTIGATION DETAILS

6.4.1. What did you have, or been advised to have?

Test/Investigation 1: _____

Test/Investigation 2: _____

Test/Investigation 3: _____

6.4.2. Why was this carried out or been suggested?

Test/Investigation 1: _____

Test/Investigation 2: _____

Test/Investigation 3: _____

6.4.3. Have you had the test, scan or investigation? Yes ☐ No ☐

If 'Yes', please go to question 6.4.4: If 'No', go to question 6.4.5

6.4.4. When was this carried out?

Test/Investigation 1: MM/YYYY _____ I don't know ☐

Test/Investigation 2: MM/YYYY _____ I don't know ☐

Test/Investigation 3: MM/YYYY _____ I don't know ☐

6.4.5. What was the result(s)?

Test/Investigation 1:

Results? _____

Test/Investigation 2:

Results? _____

Test/Investigation 3:

Results? _____

6.4.6. When is the medical investigation, test or scan (including blood tests) due or planned for?

Test/Investigation 1: MM/YYYY _____ I don't know ☐

Test/Investigation 2: MM/YYYY _____ I don't know ☐

Test/Investigation 3: MM/YYYY _____ I don't know ☐

If there is insufficient space to tell us about all the medical investigations, tests or scans (including blood tests) you have had, or been advised to have, which you have not already mentioned in this application, please continue on the 'Additional Information' section on page 54.

SECTION 6 - MEDICATIONS AND TREATMENT (CONTINUED)

6.5. In the last 5 years have you had more than 10 consecutive days off work due to any medical condition(s) which you have not mentioned in this application? Yes ☐ No ☐
If 'Yes', please go to 'Time off Work Details': If 'No', go to Section 7, 'Family History'.

TIME OFF WORK DETAILS

6.5.1. Please tell us why you were unable to work?

Time off work 1:
Reason for absence? _____

Time off work 2:
Reason for absence? _____

Time off work 3:
Reason for absence? _____

6.5.2. When was this and for how long?

Time off work 1: MM/YYYY _____ I don't know ☐

Time off work 2: MM/YYYY _____ I don't know ☐

Time off work 3: MM/YYYY _____ I don't know ☐

Time off work 1: Duration in weeks

Under 1 week	☐	2 to 4 weeks	☐	8 to 12 weeks	☐	26 to 52 weeks	☐
1 to 2 weeks	☐	4 to 8 weeks	☐	12 to 26 weeks	☐	Over 52 weeks	☐

Time off work 2: Duration in weeks

Under 1 week	☐	2 to 4 weeks	☐	8 to 12 weeks	☐	26 to 52 weeks	☐
1 to 2 weeks	☐	4 to 8 weeks	☐	12 to 26 weeks	☐	Over 52 weeks	☐

Time off work 3: Duration in weeks

Under 1 week	☐	2 to 4 weeks	☐	8 to 12 weeks	☐	26 to 52 weeks	☐
1 to 2 weeks	☐	4 to 8 weeks	☐	12 to 26 weeks	☐	Over 52 weeks	☐

If in the last 5 years have you had any further periods of more than 10 consecutive days off work due to any medical condition(s) which you have not already mentioned in this application, please continue on the 'Additional Information' section on page 54.

DATA CAPTURE FORM

SECTION 7 - FAMILY HISTORY

7.1. Have your natural parents, brothers or sisters (including half siblings) suffered from any of the following medical conditions before age 66? Yes ☐ No ☐

- Diabetes
- Stroke
- Bowel cancer
- Multiple Sclerosis
- Parkinson's disease
- Motor Neurone disease
- Cardiomyopathy
- Heart problems (including heart attack or angina)
- Polycystic kidney disease
- Female only - Breast or Ovarian cancer
- Huntington's disease
- Alzheimer's disease
- Any other hereditary conditions

If 'Yes', please go to 'Family History Details': If 'No', your Data Capture Form is now complete.

FAMILY HISTORY DETAILS

7.1.1. Please tell us which relative(s) has been affected?

Relative 1:	☐ Father	☐ Mother	☐ Brother	☐ Sister
Relative 2:	☐ Father	☐ Mother	☐ Brother	☐ Sister
Relative 3:	☐ Father	☐ Mother	☐ Brother	☐ Sister

7.1.2. What medical condition have they suffered from?

Relative 1:

☐ Diabetes	☐ Bowel cancer	☐ Alzheimer's disease
☐ Heart problems (including heart attack or angina)		☐ Multiple sclerosis
☐ Motor Neurone disease	☐ Any other hereditary condition	☐ Cardiomyopathy
☐ Huntingdon's disease	☐ Stroke	☐ Parkinson's disease
☐ Polycystic Kidney disease	☐ Female applicants only - breast or ovarian cancer	

Relative 2:

☐ Diabetes	☐ Bowel cancer	☐ Alzheimer's disease
☐ Heart problems (including heart attack or angina)		☐ Multiple sclerosis
☐ Motor Neurone disease	☐ Any other hereditary condition	☐ Cardiomyopathy
☐ Huntingdon's disease	☐ Stroke	☐ Parkinson's disease
☐ Polycystic Kidney disease	☐ Female applicants only - breast or ovarian cancer	

Relative 2:

☐ Diabetes	☐ Bowel cancer	☐ Alzheimer's disease
☐ Heart problems (including heart attack or angina)		☐ Multiple sclerosis
☐ Motor Neurone disease	☐ Any other hereditary condition	☐ Cardiomyopathy
☐ Huntingdon's disease	☐ Stroke	☐ Parkinson's disease
☐ Polycystic Kidney disease	☐ Female applicants only - breast or ovarian cancer	

7.1.2.1. If you have answered 'Any other hereditary condition?' to question 7.1.2, please tell us what medical condition your relative(s) has suffered from?

Relative 1: Medical Condition? _____

Relative 2: Medical Condition? _____

Relative 3: Medical Condition? _____

SECTION 7 - FAMILY HISTORY (CONTINUED)

7.1.3. Age at onset?

Relative 1:	Under age 40 ☐	Age 45 to 49 ☐	Age 55 to 59 ☐	Age over 65 ☐
	Age 40 to 44 ☐	Age 50 to 54 ☐	Age 60 to 65 ☐	I don't know ☐
Relative 2:	Under age 40 ☐	Age 45 to 49 ☐	Age 55 to 59 ☐	Age over 65 ☐
	Age 40 to 44 ☐	Age 50 to 54 ☐	Age 60 to 65 ☐	I don't know ☐
Relative 3:	Under age 40 ☐	Age 45 to 49 ☐	Age 55 to 59 ☐	Age over 65 ☐
	Age 40 to 44 ☐	Age 50 to 54 ☐	Age 60 to 65 ☐	I don't know ☐

FAMILY HISTORY – TESTS OR INVESTIGATIONS

7.2. Have you had, or been advised to have, tests or investigations as a result of your relative's illness? Yes ☐ No ☐
If 'Yes', please go to question 7.2.1: If 'No', your Data Capture Form is now complete.

7.2.1. Please tell us about the tests or investigations you have had or you are waiting for?

Test/Investigation 1:

Type of test or investigation? _____

Test/Investigation 2:

Type of test or investigation? _____

Test/Investigation 3:

Type of test or investigation? _____

7.2.2. Have you had the test or investigation?

Test/Investigation 1: If 'Yes', please go to question 7.2.3: If 'No', go to question 7.2.5. Yes ☐ No ☐

Test/Investigation 2: If 'Yes', please go to question 7.2.3: If 'No', go to question 7.2.5. Yes ☐ No ☐

Test/Investigation 3: If 'Yes', please go to question 7.2.3: If 'No', go to question 7.2.5. Yes ☐ No ☐

7.2.3. If yes, when was this carried out?

Test/Investigation 1: MM/YYYY_____ I don't know ☐

Test/Investigation 2: MM/YYYY_____ I don't know ☐

Test/Investigation 3: MM/YYYY_____ I don't know ☐

7.2.4. What was the result(s)?

Test/Investigation 1: Results _____

Test/Investigation 2: Results _____

Test/Investigation 3: Results _____

SECTION 7 - FAMILY HISTORY (CONTINUED)

7.2.5. When is the test or investigation due or planned for?

Test/Investigation 1: MM/YYYY _____ No appointment or date given as yet ☐

Test/Investigation 2: MM/YYYY _____ No appointment or date given as yet ☐

Test/Investigation 3: MM/YYYY _____ No appointment or date given as yet ☐

If there is insufficient space to tell us about all your family history or about any tests or investigations you have had or you are waiting for concerning this, please continue on the 'Additional Information' section on page 54.

DATA CAPTURE FORM

SECTION 8 – GENERAL HEALTH QUESTIONNAIRE

MEDICAL CONDITION 1

1. What condition has been diagnosed?

_____

_____

2. When did this condition first occur? MM/YYYY _____ I don't know ☐

3. When did you last have symptoms or are these ongoing? MM/YYYY _____ I don't know ☐

Symptoms are ongoing ☐

4. Have your symptoms been continuous? Yes ☐ No ☐

If 'Yes', please go to question 5: If 'No', go to question 4.1.

4.1. How many episodes have you suffered?

Single episode ☐ 1 to 2 episodes ☐ 3 to 4 episodes ☐ 5 episodes or more ☐

5. Please confirm what symptoms you are suffering or have suffered from?

_____

_____

6. Please confirm the severity?

Mild ☐ Mild to moderate ☐ Moderate to severe ☐

7. Is there any underlying reason for this condition? Yes ☐ No ☐

If 'Yes', please go to question 7.1: If 'No', go to question 8.

7.1. Please give full details:

_____

_____

8. Are you currently having treatment, for example any medication or physiotherapy? Yes ☐ No ☐

If 'Yes', please go to 'Current Treatment Details': If 'No', go to question 9.

CURRENT TREATMENT DETAILS

8.1. Please tell us about the type of treatment you are currently receiving, including the dosage or frequency of the treatment?

Treatment 1:

Type of treatment? _____

Dosage or frequency? _____

Treatment 2:

Type of treatment? _____

Dosage or frequency? _____

Treatment 3:

Type of treatment? _____

Dosage or frequency? _____

If there is insufficient space to tell us about all your current treatments, please continue on the 'Additional Information' section on page 54.

SECTION 8 – GENERAL HEALTH QUESTIONNAIRE (CONTINUED)

9. Has your treatment recently changed or have you had any different type of treatment in the past? Yes ☐ No ☐
If 'Yes', please go to 'Previous Treatment Details': If 'No', go to question 10.

PREVIOUS TREATMENT DETAILS

9.1. Please tell us about the type of treatment you have had in the past, including the dosage or frequency of the treatment?

Treatment 1:

Type of treatment? _____

Dosage or frequency? _____

Treatment 2:

Type of treatment? _____

Dosage or frequency? _____

Treatment 3:

Type of treatment? _____

Dosage or frequency? _____

If there is insufficient space to tell us about all the treatment you have had in the past, please continue on the 'Additional Information' section on page 54.

10. Have you had any medical investigations, tests or scans? Yes ☐ No ☐
If 'Yes', please go to 'Investigation Details': If 'No', go to question 11.

INVESTIGATION DETAILS

10.1. Please tell us about any investigations, tests or scans you have had, including the dates these were carried out and the results?

Investigation 1:

Type of investigation, test or scan? _____

When was it? MM/YYYY _____ I don't know ☐

What were the results?

_____

_____

Investigation 2:

Type of investigation, test or scan? _____

When was it? MM/YYYY _____ I don't know ☐

What were the results?

_____

_____

Investigation 3:

Type of investigation, test or scan? _____

When was it? MM/YYYY _____ I don't know ☐

What were the results?

_____

_____

If there is insufficient space to tell us about all the investigations, tests or scans you have had, please continue on the 'Additional Information' section on page 54.

SECTION 8 – GENERAL HEALTH QUESTIONNAIRE (CONTINUED)

11. Are you due to have any medical investigation, test or scan or are you awaiting any results? Yes ☐ No ☐
If 'Yes', please go to 'Future Investigation Details': If 'No', go to question 12

FUTURE INVESTIGATION DETAILS

11.1. Please tell us what you are waiting for, including when it is planned for or when your results are due?

Investigation 1:
What are you waiting for? _____
When is it planned for or when are your results due? MM/YYYY _____ I don't know ☐

Investigation 2:
What are you waiting for? _____
When is it planned for or when are your results due? MM/YYYY _____ I don't know ☐

Investigation 3:
What are you waiting for? _____
When is it planned for or when are your results due? MM/YYYY _____ I don't know ☐

If there is insufficient space to tell us about all the investigations, tests or scans you are waiting for, please continue on the 'Additional Information' section on page 54.

12. Have you been admitted to hospital with this condition? Yes ☐ No ☐
If 'Yes', please go to 'Hospital Admissions': If 'No', go to question 13.

HOSPITAL ADMISSIONS

12.1. Please tell us about any hospital admission(s), including when this was and how long you were in hospital for?

Hospital Admission 1:
Date admitted: MM/YYYY _____ I don't know ☐
Discharge date: MM/YYYY _____

Hospital Admission 2:
Date admitted: MM/YYYY _____ I don't know ☐
Discharge date: MM/YYYY _____

Hospital Admission 3:
Date admitted: MM/YYYY _____ I don't know ☐
Discharge date: MM/YYYY _____

Hospital Admission 1: Length of stay

Under 1 week ☐	2 to 4 weeks ☐	8 to 12 weeks ☐	26 to 52 weeks ☐
1 to 2 weeks ☐	4 to 8 weeks ☐	12 to 26 weeks ☐	Over 52 weeks ☐

Hospital Admission 2: Length of stay

Under 1 week ☐	2 to 4 weeks ☐	8 to 12 weeks ☐	26 to 52 weeks ☐
1 to 2 weeks ☐	4 to 8 weeks ☐	12 to 26 weeks ☐	Over 52 weeks ☐

Hospital Admission 3: Length of stay

Under 1 week ☐	2 to 4 weeks ☐	8 to 12 weeks ☐	26 to 52 weeks ☐
1 to 2 weeks ☐	4 to 8 weeks ☐	12 to 26 weeks ☐	Over 52 weeks ☐

If there is insufficient space to tell us about all your hospital admissions for this medical condition, please continue on the 'Additional Information' section on page 54.

DATA CAPTURE FORM

SECTION 8 – GENERAL HEALTH QUESTIONNAIRE (CONTINUED)

13. Have you had or are you waiting for an operation as a result of this condition? Yes ☐ No ☐
If 'Yes', please go to 'Surgery Details': If 'No', go to question 14.

SURGERY DETAILS

13.1. Please tell us about any operation(s) you have had or are waiting for, including when it was carried out or when it is planned for?

Surgery 1:
What is the nature of the surgery? _____
When was it carried out or when is it planned for? MM/YYYY_____ ☐ I don't know
☐ No appointment or date given as yet

Surgery 2:
What is the nature of the surgery? _____
When was it carried out or when is it planned for? MM/YYYY_____ ☐ I don't know
☐ No appointment or date given as yet

Surgery 3:
What is the nature of the surgery? _____
When was it carried out or when is it planned for? MM/YYYY_____ ☐ I don't know
☐ No appointment or date given as yet

If there is insufficient space to tell us about all your operations for this medical condition, please continue on the 'Additional Information' section on page 54.

14. Are you currently under review? Yes ☐ No ☐
If 'Yes', please go to 'Review Details': If 'No', go to question 15.

REVIEW DETAILS

14.1. Please tell us who you see?

Review 1:	Own GP ☐	Practice Nurse ☐	Consultant/Specialist ☐	Other ☐
Review 2:	Own GP ☐	Practice Nurse ☐	Consultant/Specialist ☐	Other ☐
Review 3:	Own GP ☐	Practice Nurse ☐	Consultant/Specialist ☐	Other ☐

14.1.1. If you have answered 'Other' to question 14.1,please tell us which health professional(s) you see:

Review 1:
Who do you see? _____

Review 2:
Who do you see? _____

Review 3:
Who do you see? _____

SECTION 8 – GENERAL HEALTH QUESTIONNAIRE (CONTINUED)

14.2. How often do you attend?

Review 1:	Weekly ☐	Monthly ☐	3 Monthly ☐	6 Monthly ☐	Yearly ☐	Other ☐
Review 2:	Weekly ☐	Monthly ☐	3 Monthly ☐	6 Monthly ☐	Yearly ☐	Other ☐
Review 3:	Weekly ☐	Monthly ☐	3 Monthly ☐	6 Monthly ☐	Yearly ☐	Other ☐

14.2.1. If you have answered 'Other' to question 14.2, please tell us how often your medical condition is reviewed:

Review 1:
How often do you attend? _____

Review 2:
How often do you attend? _____

Review 3:
How often do you attend? _____

14.3. When was your last visit?

Review 1:	MM/YYYY _____	I don't know ☐	I have not yet attended my first review ☐
Review 2:	MM/YYYY _____	I don't know ☐	I have not yet attended my first review ☐
Review 3:	MM/YYYY _____	I don't know ☐	I have not yet attended my first review ☐

If there is insufficient space to tell us about all the reviews you attend as a result of this condition, please continue on the 'Additional Information' section on page 54.

15. Have you had any time off work due to this condition? Yes ☐ No ☐
If 'Yes', please go to 'Time off Work Details': If 'No', go to question 16.

TIME OFF WORK DETAILS

15.1. Please tell us when you were off work and for how long?

Time off work 1: From MM/YYYY _____	To MM/YYYY _____	I don't know ☐
Time off work 2: From MM/YYYY _____	To MM/YYYY _____	I don't know ☐
Time off work 3: From MM/YYYY _____	To MM/YYYY _____	I don't know ☐

Time off work 1: Duration in weeks

Under 1 week ☐	2 to 4 weeks ☐	8 to 12 weeks ☐	26 to 52 weeks ☐
1 to 2 weeks ☐	4 to 8 weeks ☐	12 to 26 weeks ☐	Over 52 weeks ☐

Time off work 2: Duration in weeks

Under 1 week ☐	2 to 4 weeks ☐	8 to 12 weeks ☐	26 to 52 weeks ☐
1 to 2 weeks ☐	4 to 8 weeks ☐	12 to 26 weeks ☐	Over 52 weeks ☐

Time off work 3: Duration in weeks

Under 1 week ☐	2 to 4 weeks ☐	8 to 12 weeks ☐	26 to 52 weeks ☐
1 to 2 weeks ☐	4 to 8 weeks ☐	12 to 26 weeks ☐	Over 52 weeks ☐

If there is insufficient space to tell us about all the time you have had off work due to this condition, please continue on the 'Additional Information' section on page 54.

SECTION 8 – GENERAL HEALTH QUESTIONNAIRE (CONTINUED)

16. Are you now fully recovered with no ongoing problems? Yes ☐ No ☐
If 'Yes', please go to question 16.1: If 'No', go to question 16.2.

16.1. When did you fully recover? MM/YYYY _____ I don't know ☐

16.2. Does your medical condition affect your day to day activities or your ability to do your job in any way? Yes ☐ No ☐
If 'Yes', please go to question 16.3.

16.3. Please tell us how your condition is affecting your daily activities or your ability to work?

_____

_____

_____

_____

_____

SECTION 8 – GENERAL HEALTH QUESTIONNAIRE

MEDICAL CONDITION 2

1. What condition has been diagnosed?

_____

_____

2. When did this condition first occur? MM/YYYY _____ I don't know ☐

3. When did you last have symptoms or are these ongoing? MM/YYYY _____ I don't know ☐

Symptoms are ongoing ☐

4. Have your symptoms been continuous? Yes ☐ No ☐

If 'Yes', please go to question 5: If 'No', go to question 4.1.

4.1. How many episodes have you suffered?

Single episode ☐ 1 to 2 episodes ☐ 3 to 4 episodes ☐ 5 episodes or more ☐

5. Please confirm what symptoms you are suffering or have suffered from?

_____

_____

6. Please confirm the severity?

Mild ☐ Mild to moderate ☐ Moderate to severe ☐

7. Is there any underlying reason for this condition? Yes ☐ No ☐

If 'Yes', please go to question 7.1: If 'No', go to question 8.

7.1. Please give full details:

_____

_____

8. Are you currently having treatment, for example any medication or physiotherapy? ☐ Yes ☐ No

If 'Yes', please go to 'Current Treatment Details': If 'No', go to question 9.

CURRENT TREATMENT DETAILS

8.1. Please tell us about the type of treatment you are currently receiving, including the dosage or frequency of the treatment?

Treatment 1:

Type of treatment? _____

Dosage or frequency? _____

Treatment 2:

Type of treatment? _____

Dosage or frequency? _____

Treatment 3:

Type of treatment? _____

Dosage or frequency? _____

If there is insufficient space to tell us about all your current treatments, please continue on the 'Additional Information' section on page 54.

DATA CAPTURE FORM

SECTION 8 – GENERAL HEALTH QUESTIONNAIRE (CONTINUED)

9. Has your treatment recently changed or have you had any different type of treatment in the past? Yes ☐ No ☐
If 'Yes', please go to 'Previous Treatment Details': If 'No', go to question 10.

PREVIOUS TREATMENT DETAILS

9.1. Please tell us about the type of treatment you have had in the past, including the dosage or frequency of the treatment?

Treatment 1:

Type of treatment? _____

Dosage or frequency? _____

Treatment 2:

Type of treatment? _____

Dosage or frequency? _____

Treatment 3:

Type of treatment? _____

Dosage or frequency? _____

If there is insufficient space to tell us about all the treatment you have had in the past, please continue on the 'Additional Information' section on page 54.

10. Have you had any medical investigations, tests or scans? Yes ☐ No ☐
If 'Yes', please go to 'Investigation Details': If 'No', go to question 11.

INVESTIGATION DETAILS

10.1. Please tell us about any investigations, tests or scans you have had, including the dates these were carried out and the results?

Investigation 1:

Type of investigation, test or scan? _____

When was it? MM/YYYY _____ I don't know ☐

What were the results?

_____

_____

Investigation 2:

Type of investigation, test or scan? _____

When was it? MM/YYYY _____ I don't know ☐

What were the results?

_____

_____

Investigation 3:

Type of investigation, test or scan? _____

When was it? MM/YYYY _____ I don't know ☐

What were the results?

_____

_____

If there is insufficient space to tell us about all the investigations, tests or scans you have had, please continue on the 'Additional Information' section on page 54.

SECTION 8 – GENERAL HEALTH QUESTIONNAIRE (CONTINUED)

11. Are you due to have any medical investigation, test or scan or are you awaiting any results? Yes ☐ No ☐
If 'Yes', please go to 'Future Investigation Details': If 'No', go to question 12

FUTURE INVESTIGATION DETAILS

11.1. Please tell us what you are waiting for, including when it is planned for or when your results are due?

Investigation 1:
What are you waiting for? _____
When is it planned for or when are your results due? MM/YYYY _____ I don't know ☐

Investigation 2:
What are you waiting for? _____
When is it planned for or when are your results due? MM/YYYY _____ I don't know ☐

Investigation 3:
What are you waiting for? _____
When is it planned for or when are your results due? MM/YYYY _____ I don't know ☐

If there is insufficient space to tell us about all the investigations, tests or scans you are waiting for, please continue on the 'Additional Information' section on page 54.

12. Have you been admitted to hospital with this condition? Yes ☐ No ☐
If 'Yes', please go to 'Hospital Admissions': If 'No', go to question 13.

HOSPITAL ADMISSIONS

12.1. Please tell us about any hospital admission(s), including when this was and how long you were in hospital for?

Hospital Admission 1:
Date admitted: MM/YYYY _____ I don't know ☐
Discharge date: MM/YYYY _____

Hospital Admission 2:
Date admitted: MM/YYYY _____ I don't know ☐
Discharge date: MM/YYYY _____

Hospital Admission 3:
Date admitted: MM/YYYY _____ I don't know ☐
Discharge date: MM/YYYY _____

Hospital Admission 1: Length of stay

Under 1 week ☐	2 to 4 weeks ☐	8 to 12 weeks ☐	26 to 52 weeks ☐
1 to 2 weeks ☐	4 to 8 weeks ☐	12 to 26 weeks ☐	Over 52 weeks ☐

Hospital Admission 2: Length of stay

Under 1 week ☐	2 to 4 weeks ☐	8 to 12 weeks ☐	26 to 52 weeks ☐
1 to 2 weeks ☐	4 to 8 weeks ☐	12 to 26 weeks ☐	Over 52 weeks ☐

Hospital Admission 3: Length of stay

Under 1 week ☐	2 to 4 weeks ☐	8 to 12 weeks ☐	26 to 52 weeks ☐
1 to 2 weeks ☐	4 to 8 weeks ☐	12 to 26 weeks ☐	Over 52 weeks ☐

If there is insufficient space to tell us about all your hospital admissions for this medical condition, please continue on the 'Additional Information' section on page 54.

DATA CAPTURE FORM

SECTION 8 – GENERAL HEALTH QUESTIONNAIRE (CONTINUED)

13. Have you had or are you waiting for an operation as a result of this condition? Yes ☐ No ☐
If 'Yes', please go to 'Surgery Details': If 'No', go to question 14.

SURGERY DETAILS

13.1. Please tell us about any operation(s) you have had or are waiting for, including when it was carried out or when it is planned for?

Surgery 1:
What is the nature of the surgery? _____
When was it carried out or when is it planned for? MM/YYYY_____ ☐ I don't know
☐ No appointment or date given as yet

Surgery 2:
What is the nature of the surgery? _____
When was it carried out or when is it planned for? MM/YYYY_____ ☐ I don't know
☐ No appointment or date given as yet

Surgery 3:
What is the nature of the surgery? _____
When was it carried out or when is it planned for? MM/YYYY_____ ☐ I don't know
☐ No appointment or date given as yet

If there is insufficient space to tell us about all your operations for this medical condition, please continue on the 'Additional Information' section on page 54.

14. Are you currently under review? Yes ☐ No ☐
If 'Yes', please go to 'Review Details': If 'No', go to question 15.

REVIEW DETAILS

14.1. Please tell us who you see?

Review 1:	Own GP ☐	Practice Nurse ☐	Consultant/Specialist ☐	Other ☐
Review 2:	Own GP ☐	Practice Nurse ☐	Consultant/Specialist ☐	Other ☐
Review 3:	Own GP ☐	Practice Nurse ☐	Consultant/Specialist ☐	Other ☐

14.1.1. If you have answered 'Other' to question 14.1,please tell us which health professional(s) you see:

Review 1:
Who do you see? _____

Review 2:
Who do you see? _____

Review 3:
Who do you see? _____

SECTION 8 – GENERAL HEALTH QUESTIONNAIRE (CONTINUED)

14.2. How often do you attend?

Review 1:	Weekly ☐	Monthly ☐	3 Monthly ☐	6 Monthly ☐	Yearly ☐	Other ☐
Review 2:	Weekly ☐	Monthly ☐	3 Monthly ☐	6 Monthly ☐	Yearly ☐	Other ☐
Review 3:	Weekly ☐	Monthly ☐	3 Monthly ☐	6 Monthly ☐	Yearly ☐	Other ☐

14.2.1. If you have answered 'Other' to question 14.2, please tell us how often your medical condition is reviewed:

Review 1:
How often do you attend? _____

Review 2:
How often do you attend? _____

Review 3:
How often do you attend? _____

14.3. When was your last visit?

Review 1:	MM/YYYY _____	I don't know ☐	I have not yet attended my first review ☐
Review 2:	MM/YYYY _____	I don't know ☐	I have not yet attended my first review ☐
Review 3:	MM/YYYY _____	I don't know ☐	I have not yet attended my first review ☐

If there is insufficient space to tell us about all the reviews you attend as a result of this condition, please continue on the 'Additional Information' section on page 54.

15. Have you had any time off work due to this condition? Yes ☐ No ☐
If 'Yes', please go to 'Time off Work Details': If 'No', go to question 16.

TIME OFF WORK DETAILS

15.1. Please tell us when you was off work and for how long?

Time off work 1: From MM/YYYY _____	To MM/YYYY _____	I don't know ☐
Time off work 2: From MM/YYYY _____	To MM/YYYY _____	I don't know ☐
Time off work 3: From MM/YYYY _____	To MM/YYYY _____	I don't know ☐

Time off work 1: Duration in weeks

Under 1 week ☐	2 to 4 weeks ☐	8 to 12 weeks ☐	26 to 52 weeks ☐
1 to 2 weeks ☐	4 to 8 weeks ☐	12 to 26 weeks ☐	Over 52 weeks ☐

Time off work 2: Duration in weeks

Under 1 week ☐	2 to 4 weeks ☐	8 to 12 weeks ☐	26 to 52 weeks ☐
1 to 2 weeks ☐	4 to 8 weeks ☐	12 to 26 weeks ☐	Over 52 weeks ☐

Time off work 3: Duration in weeks

Under 1 week ☐	2 to 4 weeks ☐	8 to 12 weeks ☐	26 to 52 weeks ☐
1 to 2 weeks ☐	4 to 8 weeks ☐	12 to 26 weeks ☐	Over 52 weeks ☐

If there is insufficient space to tell us about all the time you have had off work due to this condition, please continue on the 'Additional Information' section on page 54.

SECTION 8 – GENERAL HEALTH QUESTIONNAIRE (CONTINUED)

16. Are you now fully recovered with no ongoing problems? Yes ☐ No ☐
If 'Yes', please go to question 16.1: If 'No', go to question 16.2.

16.1. When did you fully recover? MM/YYYY _____ I don't know ☐

16.2. Does your medical condition affect your day to day activities or your ability to do your job in any way? Yes ☐ No ☐
If 'Yes', please go to question 16.3.

16.3. Please tell us how your condition is affecting your daily activities or your ability to work?

_____

_____

_____

_____

_____

DATA CAPTURE FORM

SECTION 8 – GENERAL HEALTH QUESTIONNAIRE

MEDICAL CONDITION 3

1. What condition has been diagnosed?

_____

_____

2. When did this condition first occur? MM/YYYY _____ I don't know ☐

3. When did you last have symptoms or are these ongoing? MM/YYYY _____ I don't know ☐

Symptoms are ongoing ☐

4. Have your symptoms been continuous? Yes ☐ No ☐

If 'Yes', please go to question 5: If 'No', go to question 4.1.

4.1. How many episodes have you suffered?

Single episode ☐ 1 to 2 episodes ☐ 3 to 4 episodes ☐ 5 episodes or more ☐

5. Please confirm what symptoms you are suffering or have suffered from?

_____

_____

6. Please confirm the severity?

Mild ☐ Mild to moderate ☐ Moderate to severe ☐

7. Is there any underlying reason for this condition? Yes ☐ No ☐

If 'Yes', please go to question 7.1: If 'No', go to question 8.

7.1. Please give full details:

_____

_____

8. Are you currently having treatment, for example any medication or physiotherapy? Yes ☐ No ☐

If 'Yes', please go to 'Current Treatment Details': If 'No', go to question 9.

CURRENT TREATMENT DETAILS

8.1. Please tell us about the type of treatment you are currently receiving, including the dosage or frequency of the treatment?

Treatment 1:

Type of treatment? _____

Dosage or frequency? _____

Treatment 2:

Type of treatment? _____

Dosage or frequency? _____

Treatment 3:

Type of treatment? _____

Dosage or frequency? _____

If there is insufficient space to tell us about all your current treatments, please continue on the 'Additional Information' section on page 54.

SECTION 8 – GENERAL HEALTH QUESTIONNAIRE (CONTINUED)

9. Has your treatment recently changed or have you had any different type of treatment in the past? Yes ☐ No ☐
If 'Yes', please go to 'Previous Treatment Details': If 'No', go to question 10.

PREVIOUS TREATMENT DETAILS

9.1. Please tell us about the type of treatment you have had in the past, including the dosage or frequency of the treatment?

Treatment 1:

Type of treatment? _____

Dosage or frequency? _____

Treatment 2:

Type of treatment? _____

Dosage or frequency? _____

Treatment 3:

Type of treatment? _____

Dosage or frequency? _____

If there is insufficient space to tell us about all the treatment you have had in the past, please continue on the 'Additional Information' section on page 54.

10. Have you had any medical investigations, tests or scans? Yes ☐ No ☐
If 'Yes', please go to 'Investigation Details': If 'No', go to question 11.

INVESTIGATION DETAILS

10.1. Please tell us about any investigations, tests or scans you have had, including the dates these were carried out and the results?

Investigation 1:

Type of investigation, test or scan? _____

When was it? MM/YYYY _____ I don't know ☐

What were the results?

_____

_____

Investigation 2:

Type of investigation, test or scan? _____

When was it? MM/YYYY _____ I don't know ☐

What were the results?

_____

_____

Investigation 3:

Type of investigation, test or scan? _____

When was it? MM/YYYY _____ I don't know ☐

What were the results?

_____

_____

If there is insufficient space to tell us about all the investigations, tests or scans you have had, please continue on the 'Additional Information' section on page 54.

SECTION 8 – GENERAL HEALTH QUESTIONNAIRE (CONTINUED)

11. Are you due to have any medical investigation, test or scan or are you awaiting any results? Yes ☐ No ☐
If 'Yes', please go to 'Future Investigation Details': If 'No', go to question 12

FUTURE INVESTIGATION DETAILS

11.1. Please tell us what you are waiting for, including when it is planned for or when your results are due?

Investigation 1:
What are you waiting for? _____
When is it planned for or when are your results due? MM/YYYY _____ I don't know ☐

Investigation 2:
What are you waiting for? _____
When is it planned for or when are your results due? MM/YYYY _____ I don't know ☐

Investigation 3:
What are you waiting for? _____
When is it planned for or when are your results due? MM/YYYY _____ I don't know ☐

If there is insufficient space to tell us about all the investigations, tests or scans you are waiting for, please continue on the 'Additional Information' section on page 54.

12. Have you been admitted to hospital with this condition? Yes ☐ No ☐
If 'Yes', please go to 'Hospital Admissions': If 'No', go to question 13.

HOSPITAL ADMISSIONS

12.1. Please tell us about any hospital admission(s), including when this was and how long you were in hospital for?

Hospital Admission 1:
Date admitted: MM/YYYY _____ I don't know ☐
Discharge date: MM/YYYY _____

Hospital Admission 2:
Date admitted: MM/YYYY _____ I don't know ☐
Discharge date: MM/YYYY _____

Hospital Admission 3:
Date admitted: MM/YYYY _____ I don't know ☐
Discharge date: MM/YYYY _____

Hospital Admission 1: Length of stay

Under 1 week ☐	2 to 4 weeks ☐	8 to 12 weeks ☐	26 to 52 weeks ☐
1 to 2 weeks ☐	4 to 8 weeks ☐	12 to 26 weeks ☐	Over 52 weeks ☐

Hospital Admission 2: Length of stay

Under 1 week ☐	2 to 4 weeks ☐	8 to 12 weeks ☐	26 to 52 weeks ☐
1 to 2 weeks ☐	4 to 8 weeks ☐	12 to 26 weeks ☐	Over 52 weeks ☐

Hospital Admission 3: Length of stay

Under 1 week ☐	2 to 4 weeks ☐	8 to 12 weeks ☐	26 to 52 weeks ☐
1 to 2 weeks ☐	4 to 8 weeks ☐	12 to 26 weeks ☐	Over 52 weeks ☐

If there is insufficient space to tell us about all your hospital admissions for this medical condition, please continue on the 'Additional Information' section on page 54.

DATA CAPTURE FORM

SECTION 8 – GENERAL HEALTH QUESTIONNAIRE (CONTINUED)

13. Have you had or are you waiting for an operation as a result of this condition? Yes ☐ No ☐
If 'Yes', please go to 'Surgery Details': If 'No', go to question 14.

SURGERY DETAILS

13.1. Please tell us about any operation(s) you have had or are waiting for, including when it was carried out or when it is planned for?

Surgery 1:
What is the nature of the surgery? _____
When was it carried out or when is it planned for? MM/YYYY_____ ☐ I don't know
☐ No appointment or date given as yet

Surgery 2:
What is the nature of the surgery? _____
When was it carried out or when is it planned for? MM/YYYY_____ ☐ I don't know
☐ No appointment or date given as yet

Surgery 3:
What is the nature of the surgery? _____
When was it carried out or when is it planned for? MM/YYYY_____ ☐ I don't know
☐ No appointment or date given as yet

If there is insufficient space to tell us about all your operations for this medical condition, please continue on the 'Additional Information' section on page 54.

14. Are you currently under review? Yes ☐ No ☐
If 'Yes', please go to 'Review Details': If 'No', go to question 15.

REVIEW DETAILS

14.1. Please tell us who you see?

Review 1:	Own GP ☐	Practice Nurse ☐	Consultant/Specialist ☐	Other ☐
Review 2:	Own GP ☐	Practice Nurse ☐	Consultant/Specialist ☐	Other ☐
Review 3:	Own GP ☐	Practice Nurse ☐	Consultant/Specialist ☐	Other ☐

14.1.1. If you have answered 'Other' to question 14.1,please tell us which health professional(s) you see:

Review 1:
Who do you see? _____

Review 2:
Who do you see? _____

Review 3:
Who do you see? _____

SECTION 8 – GENERAL HEALTH QUESTIONNAIRE (CONTINUED)

14.2. How often do you attend?

Review 1:	Weekly ☐	Monthly ☐	3 Monthly ☐	6 Monthly ☐	Yearly ☐	Other ☐
Review 2:	Weekly ☐	Monthly ☐	3 Monthly ☐	6 Monthly ☐	Yearly ☐	Other ☐
Review 3:	Weekly ☐	Monthly ☐	3 Monthly ☐	6 Monthly ☐	Yearly ☐	Other ☐

14.2.1. If you have answered 'Other' to question 14.2, please tell us how often your medical condition is reviewed:

Review 1:
How often do you attend? _____

Review 2:
How often do you attend? _____

Review 3:
How often do you attend? _____

14.3. When was your last visit?

Review 1:	MM/YYYY _____	I don't know ☐	I have not yet attended my first review ☐
Review 2:	MM/YYYY _____	I don't know ☐	I have not yet attended my first review ☐
Review 3:	MM/YYYY _____	I don't know ☐	I have not yet attended my first review ☐

If there is insufficient space to tell us about all the reviews you attend as a result of this condition, please continue on the 'Additional Information' section on page 54.

15. Have you had any time off work due to this condition? Yes ☐ No ☐
If 'Yes', please go to 'Time off Work Details': If 'No', go to question 16.

TIME OFF WORK DETAILS

15.1. Please tell us when you was off work and for how long?

Time off work 1:	From MM/YYYY _____	To MM/YYYY _____	I don't know ☐
Time off work 2:	From MM/YYYY _____	To MM/YYYY _____	I don't know ☐
Time off work 3:	From MM/YYYY _____	To MM/YYYY _____	I don't know ☐

Time off work 1: Duration in weeks

Under 1 week ☐	2 to 4 weeks ☐	8 to 12 weeks ☐	26 to 52 weeks ☐
1 to 2 weeks ☐	4 to 8 weeks ☐	12 to 26 weeks ☐	Over 52 weeks ☐

Time off work 2: Duration in weeks

Under 1 week ☐	2 to 4 weeks ☐	8 to 12 weeks ☐	26 to 52 weeks ☐
1 to 2 weeks ☐	4 to 8 weeks ☐	12 to 26 weeks ☐	Over 52 weeks ☐

Time off work 3: Duration in weeks

Under 1 week ☐	2 to 4 weeks ☐	8 to 12 weeks ☐	26 to 52 weeks ☐
1 to 2 weeks ☐	4 to 8 weeks ☐	12 to 26 weeks ☐	Over 52 weeks ☐

If there is insufficient space to tell us about all the time you have had off work due to this condition, please continue on the 'Additional Information' section on page 54.

SECTION 8 – GENERAL HEALTH QUESTIONNAIRE (CONTINUED)

16. Are you now fully recovered with no ongoing problems? Yes ☐ No ☐
If 'Yes', please go to question 16.1: If 'No', go to question 16.2.

16.1. When did you fully recover? MM/YYYY _____ I don't know ☐

16.2. Does your medical condition affect your day to day activities or your ability to do your job in any way? Yes ☐ No ☐
If 'Yes', please go to question 16.3.

16.3. Please tell us how your condition is affecting your daily activities or your ability to work?

_____

_____

_____

_____

_____

DATA CAPTURE FORM

SECTION 8 – DIABETES QUESTIONNAIRE

5.9.1. What type of diabetes do you currently have or have had?

Type 2 ☐ Gestational diabetes (diabetes of pregnancy) ☐ Diabetes Insipidus ☐ Pre-diabetes ☐ Other ☐

5.9.1.1. If you have answered 'Other' to question 5.9.1., please tell us about the type of diabetes you suffer from?

_____

_____

5.9.2. When did this condition first occur? MM/YYYY_____ I don't know ☐

5.9.3. Do you know the result of your last HbA1c test? Yes ☐ No ☐

If 'Yes', please go to question 5.9.3.1: If 'No', go to question 5.9.4.

5.9.3.1. What was the result?

_____

_____

5.9.3.2. When was this taken? MM/YYYY_____ I don't know ☐

5.9.4. Do you check your own blood or urine for glucose? Yes ☐ No ☐

If 'Yes', please go to 'Glucose Details': If 'No', go to question 5.9.5.

GLUCOSE DETAILS

5.9.4.1. How often do you check?

☐ 4 to 8 times a day ☐ 2 to 3 times a day ☐ Once daily

☐ Once every 2 to 3 days ☐ Once a week ☐ Less than once a week

☐ Other

5.9.4.2 If you have answered 'Other' to question 5.9.4.1, please tell us how often you check your own blood or urine for glucose?

_____

_____

5.9.4.3. What is your usual result?

_____

5.9.4.4. What is your target level?

_____

5.9.5. Are you taking insulin? Yes ☐ No ☐

If 'Yes', please go to 'Insulin Details': If 'No', go to question 5.9.6.

SECTION 8 – DIABETES QUESTIONNAIRE (CONTINUED)

INSULIN DETAILS

5.9.5.1. Please tell us about the type(s) of insulin you use, the number of units and how many injections you have each day?

Insulin 1:

Type of insulin? _____

Number of units per day? _____

Number of injections per day? _____

Insulin 2:

Type of insulin? _____

Number of units per day? _____

Number of injections per day? _____

Insulin 3:

Type of insulin? _____

Number of units per day? _____

Number of injections per day? _____

If there is insufficient space to tell us about all the type(s) of insulin you use, please continue on the 'Additional Information' section on page 54.

5.9.6. Have you ever received, or are you currently receiving, any treatment or medication for your diabetes, other than insulin? Yes ☐ No ☐

If 'Yes', please go to 'Treatment or Medication Details': If 'No', go to question 5.9.7.

TREATMENT OR MEDICATION DETAILS

5.9.6.1. Please tell us about the type(s) of treatment or medication you have received, or are currently receiving, for your diabetes other than insulin, including the dosage or frequency?

Treatment or Medication 1:

Type of treatment or medication? _____

Dosage or frequency? _____

Are you still receiving this treatment? Yes ☐ No ☐

If 'No', when did this stop? MM/YYYY _____ I don't know ☐

Treatment or Medication 2:

Type of treatment or medication? _____

Dosage or frequency? _____

Are you still receiving this treatment? Yes ☐ No ☐

If 'No', when did this stop? MM/YYYY _____ I don't know ☐

Treatment or Medication 3:

Type of treatment or medication? _____

Dosage or frequency? _____

Are you still receiving this treatment? Yes ☐ No ☐

If 'No', when did this stop? MM/YYYY _____ I don't know ☐

If there is insufficient space to tell us about all the type(s) of treatment or medication you have received, or are currently receiving, for your diabetes other than insulin, please continue on the 'Additional Information' section on page 54.

SECTION 8 – DIABETES QUESTIONNAIRE (CONTINUED)

5.9.7. Has your treatment or dosage changed within the last year? Yes ☐ No ☐
If 'Yes', please go to 'Previous Treatment Details': If 'No', go to question 5.9.8.

PREVIOUS TREATMENT DETAILS

5.9.7.1. Please tell us how it has changed and when? _____

Treatment 1:

How has this changed? _____

When was this changed? MM/YYYY _____ I don't know ☐

Treatment 2:

How has this changed? _____

When was this changed? MM/YYYY _____ I don't know ☐

Treatment 3:

How has this changed? _____

When was this changed? MM/YYYY _____ I don't know ☐

If there is insufficient space to tell us about all the changes that have been made to your treatment or dosage within the last year, please continue on the 'Additional Information' section on page 54.

5.9.8. Do you attend a Diabetic clinic? Yes ☐ No ☐
If 'Yes', please go to 'Clinic Details': If 'No', go to question 5.9.9.

CLINIC DETAILS

5.9.8.1. How often do you attend?

Once a month ☐ Once every 2 to 3 months ☐ Once every 4 to 6 months ☐

Once a year ☐ Other ☐

If you have answered 'Other' to question 5.9.8.1., please tell us how often you attend?

_____

_____

5.9.8.2. When was your last visit? MM/YYYY _____ I don't know ☐

5.9.9. Have you got any secondary complications due to your diabetes? For example, eye problems, kidney damage, nerve damage, etc? Yes ☐ No ☐
If 'Yes', please go to 'Secondary Complication Details': If 'No', go to question 5.9.10.

SECTION 8 – DIABETES QUESTIONNAIRE (CONTINUED)

SECONDARY COMPLICATION DETAILS

5.9.9.1. What are the symptoms?

Symptom 1:
Nature of symptoms? _____
When did this start? MM/YYYY _____ I don't know ☐

Symptom 2:
Nature of symptoms? _____
When did this start? MM/YYYY _____ I don't know ☐

Symptom 3:
Nature of symptoms? _____
When did this start? MM/YYYY _____ I don't know ☐

If there is insufficient space to tell us about all the secondary complications you have as a result of your diabetes, please continue on the 'Additional Information' section on page 54.

5.9.10. Have you had any time off work due to your diabetes? Yes ☐ No ☐
If 'Yes', please go to 'Time off Work Details': If 'No', go to question 5.9.11.

TIME OFF WORK DETAILS

5.9.10.1. When was this and for how long?

Time off work 1: From MM/YYYY _____ To MM/YYYY _____ I don't know ☐
Time off work 2: From MM/YYYY _____ To MM/YYYY _____ I don't know ☐
Time off work 3: From MM/YYYY _____ To MM/YYYY _____ I don't know: ☐

Time off work 1: Duration in weeks

Under 1 week ☐ 2 to 4 weeks ☐ 8 to 12 weeks ☐ 26 to 52 weeks ☐
1 to 2 weeks ☐ 4 to 8 weeks ☐ 12 to 26 weeks ☐ Over 52 weeks ☐

Time off work 2: Duration in weeks

Under 1 week ☐ 2 to 4 weeks ☐ 8 to 12 weeks ☐ 26 to 52 weeks ☐
1 to 2 weeks ☐ 4 to 8 weeks ☐ 12 to 26 weeks ☐ Over 52 weeks ☐

Time off work 3: Duration in weeks

Under 1 week ☐ 2 to 4 weeks ☐ 8 to 12 weeks ☐ 26 to 52 weeks ☐
1 to 2 weeks ☐ 4 to 8 weeks ☐ 12 to 26 weeks ☐ Over 52 weeks ☐

If there is insufficient space to tell us about all the time you have had off work due to your diabetes, please continue on the 'Additional Information' section on page 54.

5.9.11. Does your condition affect your day to day activities or your ability to do your job in any way? Yes ☐ No ☐
If 'Yes', please go to question 5.9.11.1: If 'No', go to question 5.9.12.

5.9.11.1. How does it affect you?

_____

_____

5.9.12. Have you ever had any other type of diabetes or have you had sugar in your urine or gestational diabetes (diabetes in pregnancy)? Yes ☐ No ☐
If 'Yes', please provide full details on the 'Additional Information' section on page 54.

DATA CAPTURE FORM

SECTION 8 – BLOOD PRESSURE QUESTIONNAIRE

5.16.1. Is it high blood pressure or low blood pressure you are suffering from?

High Blood Pressure ☐ Low Blood Pressure ☐

5.16.2. When was this first diagnosed? MM/YYYY _____ I don't know ☐

READING DETAILS

5.16.3. What was the result of your last reading?

_____

_____

5.16.3.1. When was this taken? MM/YYYY _____ I don't know ☐

5.16.4. Do you have any symptoms? For example, headaches, double or blurred vision, dizziness, fainting etc.

Yes ☐ No ☐

If 'Yes', please go to 'Symptom Details': If 'No', go to question 5.16.5.

READING DETAILS

5.16.4.1. What are the symptoms?

Symptom 1:
Nature of symptoms? _____

Symptom 2:
Nature of symptoms? _____

Symptom 3:
Nature of symptoms? _____

5.16.4.2. How often do you experience them?

Symptom 1:
☐ Daily ☐ More than once a week ☐ Once a week
☐ Once every 2 or 3 weeks ☐ Once a month ☐ Once every 3 months
☐ Once every 6 months ☐ Once yearly ☐ Other

Symptom 2:
☐ Daily ☐ More than once a week ☐ Once a week
☐ Once every 2 or 3 weeks ☐ Once a month ☐ Once every 3 months
☐ Once every 6 months ☐ Once yearly ☐ Other

Symptom 3:
☐ Daily ☐ More than once a week ☐ Once a week
☐ Once every 2 or 3 weeks ☐ Once a month ☐ Once every 3 months
☐ Once every 6 months ☐ Once yearly ☐ Other

If you have answered 'Other' to question 5.16.4.2., please tell us exactly how often you experience your symptoms?

Symptom 1:
Frequency of symptoms? _____

Symptom 2:
Frequency of symptoms? _____

Symptom 3:
Frequency of symptoms? _____

SECTION 8 – BLOOD PRESSURE QUESTIONNAIRE (CONTINUED)

5.16.5. Have you had any investigations in relation to this condition? Yes ☐ No ☐
If 'Yes', please go to 'Investigation Details': If 'No', go to question 5.16.6.

INVESTIGATION DETAILS

5.16.5.1. Please tell us about any investigation(s) you have had, including the dates these were carried out and the results?

Investigation 1:
Type of investigation? _____
When was it? MM/YYYY _____ I don't know ☐
What were the results? _____

Investigation 2:
Type of investigation? _____
When was it? MM/YYYY _____ I don't know ☐
What were the results? _____

Investigation 3:
Type of investigation? _____
When was it? MM/YYYY _____ I don't know ☐
What were the results? _____

If there is insufficient space to tell us about all the investigations you have had, please continue on the 'Additional Information' section on page 54.

5.16.6. Are you currently receiving any treatment or medication for this condition? Yes ☐ No ☐
If 'Yes', please go to 'Current Treatment Details': If 'No', go to question 5.16.7.

CURRENT TREATMENT DETAILS

5.16.6.1. Please tell us about the type(s) of treatment or medication you are currently receiving, including the dosage or frequency?

Treatment or Medication 1:
Type of treatment or medication? _____
Dosage or frequency? _____

Treatment or Medication 2:
Type of treatment or medication? _____
Dosage or frequency? _____

Treatment or Medication 3:
Type of treatment or medication? _____
Dosage or frequency? _____

If there is insufficient space to tell us about all the treatment or medication you are currently receiving, please continue on the 'Additional Information' section on page 54.

SECTION 8 – BLOOD PRESSURE QUESTIONNAIRE (CONTINUED)

5.16.7. Has your treatment or dosage changed within the last year? Yes ☐ No ☐
If 'Yes', please go to 'Previous Treatment Details': If 'No', go to question 5.16.8.

PREVIOUS TREATMENT DETAILS

5.16.7.1. Please tell us how it was changed and when?

Previous Treatment 1:
How has this changed? _____
When was this changed? MM/YYYY _____ I don't know ☐

Previous Treatment 2:
How has this changed? _____
When was this changed? MM/YYYY _____ I don't know ☐

Previous Treatment 3:
How has this changed? _____
When was this changed? MM/YYYY _____ I don't know ☐

If there is insufficient space to tell us about all the changes that have been made to your treatment or dosage within the last year, please continue on the 'Additional Information' section on page 54.

5.16.8. Are you currently under review? Yes ☐ No ☐
If 'Yes', please go to 'Review Details': If 'No', go to question 5.16.9.

REVIEW DETAILS

5.16.8.1. How often do you attend?

Weekly ☐ Monthly ☐ 3 Monthly ☐
6 Monthly ☐ Yearly ☐ Other ☐

If you have answered 'Other' to question 5.16.8.1., please tell us how often your medical condition is reviewed:

_____

_____

5.16.8.2. When was your last visit? MM/YYYY_____ I don't know ☐ Have not yet attended first review ☐

5.16.9. Have you had any time off work due to this condition? Yes ☐ No ☐
If 'Yes', please go to 'Time off Work Details': If 'No', go to question 5.16.10.

SECTION 8 – BLOOD PRESSURE QUESTIONNAIRE (CONTINUED)

TIME OFF WORK DETAILS

5.16.9.1. When was this?

Time off work 1: From MM/YYYY _____ To MM/YYYY _____ I don't know ☐
Time off work 2: From MM/YYYY _____ To MM/YYYY _____ I don't know ☐
Time off work 3: From MM/YYYY _____ To MM/YYYY _____ I don't know: ☐

Time off work 1: Duration in weeks

Under 1 week ☐ 2 to 4 weeks ☐ 8 to 12 weeks ☐ 26 to 52 weeks ☐
1 to 2 weeks ☐ 4 to 8 weeks ☐ 12 to 26 weeks ☐ Over 52 weeks ☐

Time off work 2: Duration in weeks

Under 1 week ☐ 2 to 4 weeks ☐ 8 to 12 weeks ☐ 26 to 52 weeks ☐
1 to 2 weeks ☐ 4 to 8 weeks ☐ 12 to 26 weeks ☐ Over 52 weeks ☐

Time off work 3: Duration in weeks

Under 1 week ☐ 2 to 4 weeks ☐ 8 to 12 weeks ☐ 26 to 52 weeks ☐
1 to 2 weeks ☐ 4 to 8 weeks ☐ 12 to 26 weeks ☐ Over 52 weeks ☐

If there is insufficient space to provide us with full details regarding the time you have had off work due to your blood pressure problems, please continue on the 'Additional Information' section on page 54.

5.16.10. In the last 5 years have you had any other episodes of high or low blood pressure? Yes ☐ No ☐
If 'Yes', please provide full details on the 'Additional Information' section on page 54.

DATA CAPTURE FORM

SECTION 8 – RAISED CHOLESTEROL QUESTIONNAIRE

5.17.1. When was this condition diagnosed? MM/YYYY _____ I don't know ☐

READING DETAILS

5.17.2. What was the result of your last reading? (Please state if fasting or non-fasting)

_____

_____

5.17.2.1. When was this taken? MM/YYYY _____ I don't know ☐

5.17.3. Do you have any symptoms? For example, eye problems or abnormal urine tests? Yes ☐ No ☐
If 'Yes', please go to 'Symptom Details': If 'No', go to question 5.17.4.

SYMPTOM DETAILS

5.17.3.1. What are the symptoms?

Symptom 1:
Nature of symptoms? _____

Symptom 2:
Nature of symptoms? _____

Symptom 3:
Nature of symptoms? _____

5.17.3.2. How often do you experience them?

Symptom 1: ☐ Daily ☐ More than once a week ☐ Once a week
☐ Once every 2 or 3 weeks ☐ Once a month ☐ Once every 3 months
☐ Once every 6 months ☐ Once yearly ☐ Other

Symptom 2: ☐ Daily ☐ More than once a week ☐ Once a week
☐ Once every 2 or 3 weeks ☐ Once a month ☐ Once every 3 months
☐ Once every 6 months ☐ Once yearly Other

Symptom 3: ☐ Daily ☐ More than once a week ☐ Once a week
☐ Once every 2 or 3 weeks ☐ Once a month ☐ Once every 3 months
☐ Once every 6 months ☐ Once yearly ☐ Other

If you have answered 'Other' to question 5.17.3.2., please tell us exactly how often you experience symptoms?

Symptom 1:
Frequency of symptoms? _____

Symptom 2:
Frequency of symptoms? _____

Symptom 3:
Frequency of symptoms? _____

5.17.4. Have you had any investigations in relation to this condition? Yes ☐ No ☐
If 'Yes', please go to 'Investigation Details': If 'No', go to question 5.17.5.

SECTION 8 – RAISED CHOLESTEROL QUESTIONNAIRE (CONTINUED)

INVESTIGATION DETAILS

5.17.4.1. Please tell us about any investigation(s) you have had, including the dates these were carried out and the results?

Investigation 1:

Type of investigation? _____

When was it? MM/YYYY _____ I don't know ☐

What were the results? _____

Investigation 2:

Type of investigation? _____

When was it? MM/YYYY _____ I don't know ☐

What were the results? _____

Investigation 3:

Type of investigation? _____

When was it? MM/YYYY _____ I don't know ☐

What were the results? _____

If there is insufficient space to tell us about all the investigations you have had, please continue on the 'Additional Information' section on page 54.

5.17.5. Are you currently receiving any treatment or medication for this condition? Yes ☐ No ☐
If 'Yes', please go to 'Current Treatment Details': If 'No', go to question 5.17.6.

CURRENT TREATMENT DETAILS

5.17.5.1. Please tell us about the type(s) of treatment or medication you are currently receiving, including the dosage or frequency?

Treatment or Medication 1:

Type of treatment or medication? _____

Dosage or frequency? _____

Treatment or Medication 2:

Type of treatment or medication? _____

Dosage or frequency? _____

Treatment or Medication 3:

Type of treatment or medication? _____

Dosage or frequency? _____

If there is insufficient space to tell us about all the treatment or medication you are currently receiving, please continue on the 'Additional Information' section on page 54.

SECTION 8 – RAISED CHOLESTEROL QUESTIONNAIRE (CONTINUED)

5.17.6. Has your treatment or dosage changed within the last year? Yes ☐ No ☐
If 'Yes', please go to 'Previous Treatment Details': If 'No', go to question 5.17.7.

PREVIOUS TREATMENT DETAILS

5.17.6.1. Please tell us how it was changed and when?

Previous Treatment 1:
Type of treatment? _____
How has this changed? _____
When was this changed? MM/YYYY _____ I don't know ☐

Previous Treatment 2:
Type of treatment? _____
How has this changed? _____
When was this changed? MM/YYYY _____ I don't know ☐

Previous Treatment 3:
Type of treatment? _____
How has this changed? _____
When was this changed? MM/YYYY _____ I don't know ☐

If there is insufficient space to tell us about all the changes that have been made to your treatment or dosage within the last year, please continue on the 'Additional Information' section on page 54.

5.17.7. Are you currently under review? Yes ☐ No ☐
If 'Yes', please go to 'Review Details': If 'No', go to question 5.17.8.

REVIEW DETAILS

5.17.7.1. How often do you attend?

Weekly ☐ Monthly ☐ 3 Monthly ☐
6 Monthly ☐ Yearly ☐ Other ☐

If you have answered 'Other' to question 5.17.7.1, please tell us how often your medical condition is reviewed:

_____

_____

5.17.7.2. When was your last visit? MM/YYYY (between 2013-2018) _____ I don't know ☐

5.17.8. Have you had any time off work due to this condition? Yes ☐ No ☐
If 'Yes', please go to 'Time off Work Details': If 'No', your Data Capture Form is now complete.

SECTION 8 – RAISED CHOLESTEROL QUESTIONNAIRE (CONTINUED)

TIME OFF WORK DETAILS

5.17.8.1. When was this?

Time off work 1: From MM/YYYY _____ To MM/YYYY _____ I don't know ☐
Time off work 2: From MM/YYYY _____ To MM/YYYY _____ I don't know ☐
Time off work 3: From MM/YYYY _____ To MM/YYYY _____ I don't know ☐

Time off work 1: Duration in weeks

Under 1 week ☐ 2 to 4 weeks ☐ 8 to 12 weeks ☐ 26 to 52 weeks ☐
1 to 2 weeks ☐ 4 to 8 weeks ☐ 12 to 26 weeks ☐ Over 52 weeks ☐

Time off work 2: Duration in weeks

Under 1 week ☐ 2 to 4 weeks ☐ 8 to 12 weeks ☐ 26 to 52 weeks ☐
1 to 2 weeks ☐ 4 to 8 weeks ☐ 12 to 26 weeks ☐ Over 52 weeks ☐

Time off work 3: Duration in weeks

Under 1 week ☐ 2 to 4 weeks ☐ 8 to 12 weeks ☐ 26 to 52 weeks ☐
1 to 2 weeks ☐ 4 to 8 weeks ☐ 12 to 26 weeks ☐ Over 52 weeks ☐

If there is insufficient space to provide us with full details regarding the time you have had off work due to your raised cholesterol, please continue on the 'Additional Information' section on page 54.

DATA CAPTURE FORM

SECTION 9 – ADDITIONAL INFORMATION

This section only applies if you need more space to answer any questions.

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BRITISH FRIENDLY

It feels good to be covered