

Fortis Life UK

Medical Data Capture Form

Hypertension

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

FEMALES ONLY

- | | | | | |
|--|-----|--------------------------|----|--------------------------|
| 1. Are you currently pregnant? | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| 2. Was your raised blood pressure diagnosed during pregnancy? | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| 3. Have you had your blood pressure checked since the delivery date? | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |

4. Have you been diagnosed with any of the following?
- | | | | | |
|--|-----|--------------------------|----|--------------------------|
| Heart defect or heart disorder | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| Kidney problems or urine abnormalities | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| None of the above | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |

5. Are you currently on treatment for raised blood pressure?
- | | | | | |
|--|-----|--------------------------|----|--------------------------|
| Never been on treatment | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| No current treatment and discharged from follow up | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| No current treatment but currently under follow up | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| Currently on treatment | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| Stopped treatment without medical approval. | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |

6. When was your blood pressure last reviewed?

7. At your last review for raised blood pressure were you advised of any of the following?
- | | | | | |
|--|-----|--------------------------|----|--------------------------|
| Advised to start or increase treatment | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| Treatment remained the same or has been decreased | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| Treatment was stopped | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| Advised to attend a review in less than 6 months | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| Advised to attend a review in 6 months time or later | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| Discharged from follow up | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| Referred to a specialist | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |

8. Do you know what your last blood pressure reading was?

First Part of reading (systolic)	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Second Part of reading (diastolic)				

Asthma

(mild asthma, allergic asthma, seasonal asthma)

1. Is your asthma made worse by your occupation?

Yes No

2. Were the first symptoms of this condition more than 2 years ago?

Yes No

3. Have you been admitted to hospital within the last 2 years with this condition?

Yes No

4. Have you taken more than one week's course of oral steroids (tablets or liquid) in the last 2 years?

Yes No

5. How many asthma attacks have you had in the last 2 years?

.....

6. How many days have you taken off work because of this condition in the last 2 years?

.....

7. Have you had an episode of status asthmaticus in the last 12 months?

Yes No

High Cholesterol

(raised cholesterol, raised lipids)

1. Have you been diagnosed with any of the following?

Heart or circulatory problems

Yes No

Kidney problems or urine abnormalities

Yes No

Familial hypercholesterolemia

Yes No

None of the above

Yes No

2. Are you currently on treatment for raised cholesterol?

Never been on treatment

Yes No

No current treatment and discharged from follow up

Yes No

No current treatment but currently under follow up

Yes No

Currently on treatment or diet controlled

Yes No

Stopped treatment without medical approval.

Yes No

3. At the last review of your cholesterol were you advised any of the following?

Advised to start or increase treatment

Yes No

Treatment remained the same or has been decreased

Yes No

Treatment was stopped

Yes No

Advised to attend a review in less than 12 months

Yes No

Advised to attend a review in 12 months time or later

Yes No

Discharged from follow up

Yes No

Referred to a specialist

Yes No

4. When was your cholesterol last reviewed?

.....

5. Please advise your last cholesterol reading (if known)

.....

Diabetes mellitus

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

FEMALES ONLY

1. Was your condition diagnosed during pregnancy? Yes No
2. Are you currently pregnant? Yes No
3. When did you last experience symptoms of this condition? Yes No
4. Have you ever had any heart disease or a stroke?
Yes No
5. Have you had a diabetic (hyperglycaemic) or insulin (hypoglycaemic) coma in the past 3 years?
Yes No
6. What age were you when this condition was diagnosed?
.....
7. Have you ever had high blood pressure?
Yes No
8. Have you ever had raised cholesterol?
Yes No
9. Have you ever had any problems with your eyes (not including normal use of glasses, lenses etc)?
Yes No
10. Have you ever had any numbness or tingling in your feet or legs?
Yes No
11. Have you ever had any albumin or protein in your urine or any kidney problems?
Yes No
12. Has your treatment increased or have you been advised to have more frequent reviews in the last year?
Yes No
13. When did you last have an HbA1c (glycosylated haemoglobin) reading?
.....

14. Which of these bands did your last HbA1c reading fall into?

- | | | | | |
|-------------------|-----|--------------------------|----|--------------------------|
| 8 or less | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| Between 8 and 9.5 | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| More than 9.5 | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| Not known | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |

IF ANSWER TO QUESTION 14 = 8 OR LESS

15. What value was your last HbA1c reading

.....

16. Which of these bands does your blood sugar reading normally fall into?

- | | | | | |
|--------------|-----|--------------------------|----|--------------------------|
| Below 8 | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| 8.1 to 9.0 | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| 9.1 to 11.0 | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| 11.1 or more | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |
| Not known | Yes | <input type="checkbox"/> | No | <input type="checkbox"/> |

Backache

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

1. Are you awaiting an operation for this condition? Yes No

No further questions if you are applying for life or Critical Illness only

Total and Permanent disability, Income Protection and waiver of premium benefits

2. Have you had surgery for this condition? Yes No

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

No symptoms in the last 2 years	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Minor symptoms (e.g. early morning stiffness), no significant effect on lifestyle or mobility	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Restriction in previous activities or pastimes	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Regular, persistent pain, limited range of activities, use of aids to assist mobility	Yes <input type="checkbox"/>	No <input type="checkbox"/>

4. When did you last experience symptoms of this condition?

.....

5. How many days off work have you had with this condition?

.....

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

.....

7. Where did you suffer pain? (Choose all that apply)

Neck	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Upper back	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Central back	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Lower back	Yes <input type="checkbox"/>	No <input type="checkbox"/>
General back pain	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Heartburn

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

1. Have you been told that your symptoms are complicated by or related to another condition ?

Ulcer	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Barrett's Oesophagus	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Oesophageal stricture or obstruction	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Hiatus hernia	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Another condition	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
No related conditions	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>

2. Have you ever been referred to a specialist or required hospital investigations because of this condition?

Yes No

IF ANSWER TO QUESTION 2 = YES

3. Were you told that the results of your investigations were normal?

All normal	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
They were not normal	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Still awaiting investigations or results	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Not sure	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>

4. Have you sought medical advice from your GP for this condition?

Yes No

5. What treatment were you recommended following your review (please check all that apply)?

No treatment and not under any planned follow ups or investigations	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Advised over the counter medication only when needed	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Given regular prescription medication (e.g. omeprazole, lansoprazole, ranitidine or cimetidine)	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Just advised to cut down on triggers such as coffee, smoking or fatty foods	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Have been advised to have further investigation or follow up	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>

6. Have the symptoms started or increased in severity or frequency in the past 6 months?

Yes No

Heart disease

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

1. Have you had surgery for this condition?

Yes

No

IF QUESTION 1 = YES

2. When was the surgery performed? (please give approximate date)

.....

3. Which best describes your symptoms since your condition was diagnosed or surgery was performed?

Normal physical activity does not cause undue fatigue or chest pain

Physical activity such as rapidly walking and climbing stairs causes some fatigue or chest pain

Chest pain, fatigue or palpitations on a physical activity such a gentle walk on level ground or climbing a flight of stairs

Chest pain, fatigue or palpitations when resting

IF QUESTION 1 = NO

4. Which best describes your symptoms within the last year?

Normal physical activity does not cause undue fatigue or chest pain

Physical activity such as rapidly walking and climbing stairs causes some fatigue or chest pain

Chest pain, fatigue or palpitations on a physical activity such a gentle walk on level ground or climbing a flight of stairs

Chest pain, fatigue or palpitations when resting

5. When was this condition first diagnosed?

.....

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

.....

7. Are you awaiting specialist investigations or surgery for this condition?

Yes

No

Musculo-skeletal injuries

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

1. Please choose the site of the musculoskeletal injury from the following:

Skull

Yes No

Spine

Yes No

Hands (including fingers), toes, jaw, collar bone, cartilages & ligaments

Yes No

Knee, shoulder, feet, arms, wrist, elbows, hips & femur, leg (including ankle)

Yes No

Pelvis

Yes No

2. Have you fully recovered from this condition?

Yes No

3. What was the cause of the injury?

Accident or injury

Yes No

Medical condition

Yes No

IF ANSWER TO QUESTION 3 = MEDICAL CONDITION

4. Please tell us the name of the underlying medical condition?

.....

5. Are you currently awaiting an operation for this condition?

Yes No

6. How much time have you had off work in the last year because of this condition?

.....

7. Please give us full details of this condition including dates

.....

.....

.....

Depression

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

1. When did you last experience symptoms of this condition?

.....

2. Are you currently on treatment for this condition?

Yes No

3. Which of the following have you visited regarding this condition in the last five years?

GP

Yes No

Nurse / CBT

Yes No

Psychiatrist

Yes No

Inpatient treatment at hospital

Yes No

None of these

Yes No

4. How many days have you taken off work because of this condition in the last two years?

.....

5. Was your condition related to a specific event?

Yes No

6. What type of treatment are you currently taking?

Antipsychotic medication e.g. Chlorpromazine

Yes No

Antimanic medication e.g. Lithium

Yes No

Antidepressant medication e.g. Fluoxetine, Citalopram

Yes No

Herbal medication e.g. St John's Wort

Yes No

Other medication

Yes No

7. When was this condition first diagnosed?

Within the last month

Yes No

One to 6 months

Yes No

6 to 12 months

Yes No

More than 12 months ago

Yes No

8. Have you ever taken an overdose of drugs or attempted suicide?

Yes

No

IF ANSWER TO QUESTION 9 = YES

9. Please give the approximate date of your overdose or suicide attempt

.....

10. Please provide any further information on your depression and suicide attempt

.....

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Growths, cysts and lumps

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

1. Has the growth been described as one of the following?

Malignant or cancerous

Yes No

Non-malignant, benign or non-cancerous

Yes No

Don't know

Yes No

2. Where was the site of the growth?

Breast

Yes No

Kidney

Yes No

Brain

Yes No

Spine

Yes No

Ovary

Yes No

Skin

Yes No

Other

Yes No

3. When was the growth first discovered (please give approximate date)?

.....

4. Have you sought medical attention regarding this condition?

Yes No

5. Has the growth become painful, bled, increased in size or changed colour whether or not you have seen a medical professional?

Yes No

6. Are you waiting for any investigations, or the results of investigations for this condition?

Yes No

7. What was the growth diagnosed as?

Mole

Yes No

Freckle

Yes No

Cyst

Yes No

Birthmark

Yes No

Ganglion

Yes No

Wart

Yes No

Nasal polyp

Yes No

Compound Naevus

Yes No

Keratosis

Yes No

Histiocytoma

Yes No

Basal cell carcinoma

Yes No

Not Sure

Yes No

None of the above

Yes No

8. Has the growth been completely removed?

Yes

Yes No

No

Yes No

Disappeared without surgery

Yes No

9. Are you under regular follow up for this or any other growth, lump, cyst or mole?

Yes No

10. Are you receiving any treatment or undergoing any follow ups for this condition?

Yes No

IF GROWTH HAS BEEN REMOVED OR MEDICAL ATTENTION HAS BEEN SOUGHT

11. Have you had, or are you scheduled to have any treatment or follow-up following its removal or disappearance (eg. tablets, radiotherapy, chemotherapy) ?

Yes No

12. Since you sought medical attention for this condition, has the growth become painful, bled, increased in size or changed colour ?

Yes No