Medical data capture form

10 most commonly disclosed medical conditions

Guidance

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

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

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Please confirm before completing this form

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○ **Yes**   ○ **No**

Asthma

(Mild asthma, allergic asthma, seasonal asthma)

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

Difficulty walking for 200m (over a period of more than one week)	◯ Yes	◯ No
Breathlessness or wheezing even when resting (over a period of more than one week)	◯ Yes	◯ No
You have needed to use home oxygen treatment	◯ Yes	◯ No
None of these	◯ Yes	◯ No

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

If the answer is yes, please tell us the:

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

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

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

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

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

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

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

Q5. How often do you have symptoms?

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

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

Q6. Have you had to take your medication more often or has the dose increased or type of medication changed in the last year? (Please don't answer this question if you answered yes to Q5 B. or Q5 C.) Yes No

If your smoker status is smoker

Q7. On average, how many cigarettes do you smoke per day?

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

Q8. Have you had any of these conditions?

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

Q9. How many chest infections have you had in the last two years; including attacks of bronchitis and lower respiratory tract infections?

Q10. Do any of the following apply to your symptoms?

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

Backache

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

Q1. Are you awaiting any of the following?

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

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

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

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

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

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

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

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

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

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

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

Q7. How many days off work have you had with this condition?

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

Depression

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

Q1. When was this condition first diagnosed?

Q2. When did you last have symptoms of this condition?

Q3. Which of the following have you visited or been referred to regarding this condition in the last five years?
(Please tick all that apply)

GP	◯ Yes	◯ No
CBT or counsellor	◯ Yes	◯ No
Psychiatrist	◯ Yes	◯ No
Community Mental Health Team	◯ Yes	◯ No
Inpatient treatment at hospital or Crisis team	◯ Yes	◯ No
None of these	◯ Yes	◯ No

Q4. How much time off your normal work or daily activities have you taken for this condition in the last 12 months?

Q5. Have you taken, or been advised to take, any medication in the last five years for this condition? ◯ Yes ◯ No

If your answer to Q5 was yes, please answer questions 6 and 7

Q6. What type of medication did you take or were you advised to take?
(Please tick all that apply)

Antipsychotic medication, e.g. Chloropromazine	◯ Yes	◯ No
Antimanic medication, e.g. Lithium	◯ Yes	◯ No
Antidepressant medication, e.g. Fluoxetine, Citalopram, Sertraline, Venlafaxine	◯ Yes	◯ No
Herbal medication, e.g. St John’s Wort	◯ Yes	◯ No
Other medication	◯ Yes	◯ No

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Q7. Has there been any change to your treatment in the last year?

No change - same type and amount of medication	◯ Yes	◯ No
Amount of medication has increased	◯ Yes	◯ No
Amount of medication has decreased on medical advice	◯ Yes	◯ No
Amount of medication has decreased for other reasons	◯ Yes	◯ No
Type of medication has changed	◯ Yes	◯ No
Medication hasn't been taken in the last year	◯ Yes	◯ No

Please answer the following questions.

Q8. Was your condition related to a specific event? ◯ Yes ◯ No

Q9. Have you ever:

(please tick all that apply)

Taken an overdose	◯ Yes	◯ No
Attempted suicide	◯ Yes	◯ No
Had suicidal feelings	◯ Yes	◯ No
Self-harmed	◯ Yes	◯ No
None of these	◯ Yes	◯ No

Q10. How many times have you taken an overdose, attempted suicide, had suicidal feelings or self-harmed?

Q11. Please give the approximate date of your last overdose, suicide attempt, suicidal feelings or self-harm.

Q12. Please provide any further information on your depression, overdose, attempted suicide, suicidal feelings or self-harm including the approximate dates of each occurrence, and the circumstances behind your illness and how it has affected you.

Diabetes mellitus

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

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

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

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

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

Q3. At what age were you diagnosed with diabetes?
(If you are not diagnosed with diabetes, the age you were found to have raised blood sugar.)

Q4. Have you been diagnosed with diabetes within the last six months? ◯ Yes ◯ No

Q5. Was your last diabetes review within the last year? ◯ Yes ◯ No

If your smoker status is smoker

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

Q7. Have you ever had any of the following symptoms or conditions?
(Please tick all that apply)

Angina, a heart attack or heart disease	◯ Yes	◯ No
Stroke or mini stroke	◯ Yes	◯ No
Kidney disease or reduced kidney function	◯ Yes	◯ No
Poor circulation in legs or feet, including gangrene, amputation or chronic foot ulcers	◯ Yes	◯ No
None of these	◯ Yes	◯ No

Q8. Have you ever had any of the following symptoms or conditions?

(Please tick all that apply)

Protein or blood in your urine	◯ Yes	◯ No
Numbness or tingling in the hands or feet	◯ Yes	◯ No
Lost some vision due to diabetes	◯ Yes	◯ No
Admission to hospital for very low or very high amounts of sugar in your blood (hypoglycaemia or hyperglycaemia) within the last 12 months	◯ Yes	◯ No
None of these	◯ Yes	◯ No

Q9. At your last diabetic review, what were you told about the control of your diabetes and treatment?

Example:

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

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

If you had answered Yes to Advised diabetic control was less than satisfactory or needed improvement in Q9, please answer Q10.

Q10. Has your HbA1c reading been over 10% (or 86 mmol) in the last 2 years?

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

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Growths, cysts, lumps etc

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

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

It has been completely and totally removed	◯ Yes	◯ No
It disappeared, or was drained without surgery	◯ Yes	◯ No
It is still present or has only partially been removed	◯ Yes	◯ No

Q2. Are you waiting for:

A. Investigations or the results of investigations	◯ Yes	◯ No
B. An operation or other type of procedure or treatment	◯ Yes	◯ No
C. Neither of these	◯ Yes	◯ No

If you answered Yes to options A or B to Q2, you do not need to answer any more questions in this section. Please go to page 15 to complete the rest of the questions.

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

A history of rodent ulcer or basal cell carcinoma can be disregarded

If you are male please answer this question, otherwise, skip to Q6.

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

On skin	◯ Yes	◯ No
Kidney	◯ Yes	◯ No
Brain	◯ Yes	◯ No
Spine	◯ Yes	◯ No
Testicle	◯ Yes	◯ No
Prostate	◯ Yes	◯ No
Breast	◯ Yes	◯ No
Bowel or rectum	◯ Yes	◯ No
Other	◯ Yes	◯ No

If growth was located on the testicle:

Q5. Was your testicular lump diagnosed as any of the following?

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

If you are female please answer Q6.

Q6. Where was/is the growth, cyst, lump or polyp?

On skin	◯ Yes	◯ No
Kidney	◯ Yes	◯ No
Brain	◯ Yes	◯ No
Spine	◯ Yes	◯ No
Breast	◯ Yes	◯ No
Ovary	◯ Yes	◯ No
Bowel or rectum	◯ Yes	◯ No
Cervix, uterus or endometrium	◯ Yes	◯ No
Other	◯ Yes	◯ No

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

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

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

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

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

Q10. Have you been fully discharged with no further follow-ups required? ◯ Yes ◯ No

Q11. Since you sought medical attention for this condition, has the growth or lump changed in appearance or have you had any further symptoms? ◯ Yes ◯ No

Q12. Has the growth, cyst, lump or polyp been diagnosed as any of the following?

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

If the location of the growth, lump or mole was on the skin, please answer Q13, 14 and 15:

Q13. Have you had five or more moles or skin abnormalities examined or treated, or have you undergone or been advised to undergo mole mapping? ◯ Yes ◯ No

Q14. When were you most recently seen or reviewed about a skin abnormality?

Q15. Do you have a family history of skin cancer or multiple mole syndrome?

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

All applicants answer Q16

Q16. Please describe the growth, cyst or lump in your own words including where it was situated, any symptoms, and why you have not sought any medical advice.

If the answer to Q4 is Other, or Q12 is Not Sure or None of These please answer the following questions:

Q17. Where was the growth situated?

Q18. What was the name of the growth?

Q19. When was the growth first discovered?

Q20. What treatment did you receive for the growth?

Q21. Please describe this condition in your own words including details of any treatment, follow ups or investigations.

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Heartburn

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

Q1. Have you been told that your symptoms are caused by, or do you have any of the following?

Ulcer	◯ Yes	◯ No
Barret's oesophagus	◯ Yes	◯ No
Oesophageal stricture or obstruction	◯ Yes	◯ No
Hiatus hernia	◯ Yes	◯ No
More than one of these conditions	◯ Yes	◯ No
Another condition	◯ Yes	◯ No
No related conditions	◯ Yes	◯ No

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

If the answer to Q1 is Another condition, please tell us the name of the condition:

Q2. Have you sought medical advice for these symptoms?

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

If answer to Q2 is Not yet, but I intend to seek advice, you do not need to complete anymore questions in this section.

Q3. When did you first have these symptoms?

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Q4. Do any of the following apply to your symptoms in the last 12 months?
Please select all that apply.

They have got worse, changed or increased in frequency	◯ Yes	◯ No
I have daily symptoms or have symptoms most days	◯ Yes	◯ No
Lost weight without dieting or increasing exercise	◯ Yes	◯ No
Difficulty swallowing food, experienced choking episodes	◯ Yes	◯ No
Vomited blood	◯ Yes	◯ No
None of these	◯ Yes	◯ No

Q5. How many days have you taken off work because of this condition in the last 12 months?

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

Q6. Please tell us about your time off work including the severity of symptoms, treatment, duration, how long you have had this condition and whether you have recovered.

Q7. Which of the following applies to you for this condition?

Due to see a hospital specialist or awaiting investigations	◯ Yes	◯ No
Have seen a hospital specialist or had investigations in the last 12 months	◯ Yes	◯ No
I have had hospital investigations in the past, but more have been planned	◯ Yes	◯ No
None of these	◯ Yes	◯ No

If the answer to Q7 is Have seen a hospital specialist or had investigations in the last 12 months, please answer the following:

Q8. What was the outcome of your investigations?

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

If answer to Q1 is Another condition, please answer the following questions:

Q9. Please describe your symptoms including the severity, frequency, how long they lasted, and whether they continue.

Q10. Please tell us the name of the condition

Q11. When did you last have symptoms of this condition?

Q12. Please describe your symptoms including the severity, frequency and how long you have had them.

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Heart disease

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

Q1. Were you first diagnosed with this condition within the last six months? ◯ Yes ◯ No

If the answer to Q1 is yes, then there's no need to answer the remaining questions

Q2. At what age did you first experience symptoms for your condition? ______

Q3. Have you ever been diagnosed with any of the following?

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

Q4. Have you had a heart attack? ◯ Yes ◯ No

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

Q5. How many times have you suffered from a heart attack? ______

Q6. When was your last heart attack? ______

Q7. Have you had an operation for this condition? ◯ Yes ◯ No

If the answer to Q7 is yes, please answer Q8-13. If no, skip to Q14

Q8. On what date was your operation carried out?

Q9. Have you suffered from chest pains or shortness of breath in the last three months? ◯ Yes ◯ No

Q10. Are you on treatment for raised blood pressure? ◯ Yes ◯ No

Q11. Are you on treatment for raised cholesterol? ◯ Yes ◯ No

Q12. Have you suffered with palpitations or an irregular heartbeat in the last three months? ◯ Yes ◯ No

Q13. Please advise the number of vessels that were treated

Q14. In the last 12 months have you had?

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

Q15. When did you last see your GP or a specialist for this condition (including routine reviews)?

Q16. Are you awaiting specialist investigations or an operation for this condition? ◯ Yes ◯ No

Q17. When did you last have a stress ECG or echocardiography?

Within the last year	◯ Yes	◯ No
One to three years ago	◯ Yes	◯ No
Three to five years ago	◯ Yes	◯ No
Over five years ago	◯ Yes	◯ No

High cholesterol

(Raised cholesterol, raised lipids)

Q1. Do you also have diabetes? ◯ Yes ◯ No

Q2. Do you also have raised blood pressure? ◯ Yes ◯ No

Q3. Are you waiting to have a hospital investigation, the results of an investigation or to see a hospital specialist for raised cholesterol or blood pressure? ◯ Yes ◯ No

We do not need to know about routine blood pressure check-ups at your General Practitioner surgery.

Q4. Have you been diagnosed with an enlarged heart, other heart problems, kidney or bladder problems? ◯ Yes ◯ No

If the answer to Q3 or Q4 is yes, then there is no need to answer the remaining questions in this section

Q5. Have you ever been advised to visit a hospital lipid clinic? ◯ Yes ◯ No

Q6. When a medical professional last tested your cholesterol, was the reading above 6.5? ◯ Yes ◯ No ◯ Don't Know

If your reading was 6.5 or less, skip to Q9. If it is yes (above 6.5), go to Q8 or if don't know, please answer the next question

Q7. At that last check up, did the medical professional tell you any of the following about your cholesterol level?

- It was normal ◯
- It was high ◯
- It was slightly higher than normal ◯
- Don't know ◯

If you answered normal, skip to Q9

Q8. When did you last have your cholesterol tested by a medical professional?

- Within the last 12 months ◯
- 13 months to 24 months ◯
- More than 24 months ago ◯

If you answered More than 24 months ago you do not have to answer any more questions in this section

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Q9. Are you taking prescription medication for your cholesterol?

◯ Yes ◯ No

If you answered yes, please skip to Q11

Q10. Have you ever been prescribed or advised to take prescription medication for this?

◯ Yes ◯ No

If you answered no, please skip to Q12

Q11. Did you start taking medication for this in the last 6 months, including restarting medication after a period of not taking it?

◯ Yes ◯ No

If your smoker status is smoker

Q12. On average, how many cigarettes do you smoke per day?

Q13. Your surgery will have asked you to have your cholesterol checked at regular intervals, do you attend these checks ups?

◯ Yes ◯ No

If you answered Yes to Q13, you do not need to answer any more questions in this section.
If you answered No to Q13, please answer questions 14, 15 and 16.

Q14. Please tell us how often you go to have your cholesterol checked and why you do not always attend?

Q15. Is your cholesterol well controlled and do you take your prescription medication as advised?

Q16. When was your cholesterol last checked and what was the reading, if known?

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Hypertension

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

Q1. Do you also have diabetes? ◯ Yes ◯ No

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

Q3. Are you waiting to have a hospital investigation, the results of an investigation or to see a hospital specialist for raised cholesterol or blood pressure?

We do not need to know about routine blood pressure check-ups at your General Practitioner surgery.

◯ Yes ◯ No

Q4. Have you been diagnosed with an enlarged heart, other heart problems, kidney or bladder problems? ◯ Yes ◯ No

If the answer to Q3 or Q4 is yes, then there is no need to answer the remaining questions in this section

If your smoker status is smoker

Q5. On average, how many cigarettes do you smoke per day?

Q6. Are you taking prescription medication to treat your blood pressure? ◯ Yes ◯ No

If you are currently on treatment, please answer Q7 - 9, otherwise skip to Q10

Q7. Have you been taking blood pressure medication for longer than 6 months? ◯ Yes ◯ No

Q8. Have you been told to do any of the following with your blood pressure medication in the last 12 months?

Take it more regularly ◯

Increase medication or change to a different type ◯

Reduce medication ◯

No change to medication ◯

Q9. Your surgery will have asked you to have your blood pressure checked at regular intervals, do you attend these check ups?

- ◯ Yes
- ◯ No

If you are not on treatment

Q10. Please tell us why prescription medication wasn't needed from the following options:

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

Q11. When was your blood pressure last checked by a medical professional?

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

Q12. When your blood pressure was last checked when were you told to have it checked again? Please select the closest match.

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

If you are female aged 29 or under please answer the next question, otherwise, skip to Q14

Q13. Was your raised blood pressure caused by pregnancy or the oral contraceptive pill?

- ◯ Yes
- ◯ No

If you answered no to Q13 or you are male aged 29 and under, please answer the next question

Q14. Please tell us about your raised blood pressure, including the cause, the results of any investigations, when it was diagnosed and when it returned to normal.

Musculo-skeletal injuries

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

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

Skull	◯ Yes	◯ No
Spine	◯ Yes	◯ No
Hands (inc. fingers), toes, jaw, collar bone, cartilages and ligaments	◯ Yes	◯ No
Knees, shoulder, feet, arms, wrist, elbows, hips and femur, leg (inc. ankle)	◯ Yes	◯ No
Pelvis	◯ Yes	◯ No

Q2. What was the cause of the injury?

Accident or injury	◯ Yes	◯ No
Medical condition	◯ Yes	◯ No

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

Q3. Are you currently awaiting an operation for this condition? ◯ Yes ◯ No

Q4. How many days have you taken off work because of this condition in the last 2 months?

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

If you have not fully recovered from this condition, please answer the following questions:

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

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

Q8. How much time have you had off work with this?

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