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

Please be aware, if you select 'No' we won't be able to process your details in relation to your application

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 seven days or less	◯ Yes	◯ No
Yes, steroid tablets for eight 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 an operation for this condition? ◯ Yes ◯ No

Q2. Have you had surgery for this condition? ◯ Yes ◯ No

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

No symptoms in the last two years	◯ Yes ◯ No
Minor symptoms (eg early morning stiffness), no significant effect on lifestyle or mobility	◯ Yes ◯ No
Restriction in previous activities or pastimes	◯ Yes ◯ No
Persistent pain, limited range of activities, use of aids to assist mobility	◯ Yes ◯ No
Bedridden or confined to a wheelchair with little or no self care	◯ Yes ◯ No

Q4. When did you last have symptoms of this condition? ☐

Q5. Where did you suffer pain? (Please tick all that apply)

Neck	◯ Yes ◯ No
Upper back	◯ Yes ◯ No
Central back	◯ Yes ◯ No
Lower back	◯ Yes ◯ No
General back pain	◯ Yes ◯ No

Q6. How many days off work have you had with this condition? ☐

Q7. On how many separate occasions have you experienced symptoms of this condition? ☐

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 regarding this condition in the last five years? (Please tick all that apply)

GP	◯ Yes	◯ No
Nurse/CBT	◯ Yes	◯ No
Psychiatrist	◯ Yes	◯ No
Inpatient treatment at hospital	◯ Yes	◯ No
None of the these	◯ Yes	◯ No

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

Q5. Are you currently on treatment for this condition? ◯ Yes ◯ No

If currently on treatment please answer questions 6 and 7, otherwise skip to question 8

Q6. What type of treatment are you currently taking? (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	◯ Yes	◯ No
Herbal medication, e.g. St John's Wort	◯ Yes	◯ No
Other medication	◯ Yes	◯ No

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

If not currently on treatment, please answer questions 8, 9 and 10

Q8. Have you ever taken medication for this condition? ◯ Yes ◯ No

Q9. Have you ever been advised to take medication for this condition? ◯ Yes ◯ No

Q10. What type of treatment 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	◯ Yes	◯ No
Herbal medication, e.g. St John's Wort	◯ Yes	◯ No
Other medication	◯ Yes	◯ No

Please answer the following questions.

Q11. Was your condition related to a specific event? ◯ Yes ◯ No

Q12. Have you ever required inpatient treatment? ◯ Yes ◯ No

Q13. Have you ever taken an overdose of drugs, attempted suicide or had suicidal feelings? ◯ Yes ◯ No

If the answer to question 13 is yes, please answer the following

Q14. How many times have you attempted suicide or had suicidal feelings?

Q15. Please give the approximate date of your overdose, suicide attempt or suicidal feelings (if you have had more than one please give the latest date)?

Q16. Please provide any further information on your depression and suicide attempt or feelings

Diabetes mellitus

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

If the answer to question 1 is yes, you will also need to complete page 19:

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

If the answer to question 2 is yes, you will also need to complete page 17:

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

Growths, cysts, lumps etc

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

Q1. Are you waiting for any investigations, or the results of investigations, for this condition? ◯ Yes ◯ No

Q2. Was the growth located on the skin? ◯ Yes ◯ No

If the growth was not located on the skin, please skip to question 10
If the growth was located on the skin, please continue with question 3

Q3. Has the growth been completely and totally removed?

It has been completely and totally removed ◯ Yes ◯ No

It disappeared without surgery ◯ Yes ◯ No

It has not been completely and totally removed ◯ Yes ◯ No

Q4. Who have you sought medical advice from for this condition?

GP only ◯ Yes ◯ No

Both my GP and a dermatologist ◯ Yes ◯ No

A dermatologist only ◯ Yes ◯ No

I have not sought medical advice ◯ Yes ◯ No

You only need to answer question 5 if you have not sought medical advice

Q5. Are you intending to seek the advice of a medical practitioner for this condition? ◯ Yes ◯ No

If you answered yes to question 5, there are no more questions

Q6. When was the growth first discovered? (Please give the approximate date) ☐

Q7. Since you sought medical attention for this condition, has the growth become painful, bled, increased in size or changed colour? ◯ Yes ◯ No

If you answered yes to question 7, there are no more questions

Q8. Are you under regular follow up or have you been advised to re-attend your GP or a specialist for this or any other growth, lump, cyst or mole? ◯ Yes ◯ No

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Q9. Has the growth ever been described as malignant or cancerous? If no, what was the growth diagnosed as? ◯ Yes ◯ No

Birthmark or freckle ◯ Yes ◯ No

Mole, cyst or skin tag ◯ Yes ◯ No

Rodent ulcer or basal cell carcinoma ◯ Yes ◯ No

Nasal polyp ◯ Yes ◯ No

Sebaceous/sebhorrhoeic keratosis or sebaceous/sebhorrhoeic wart ◯ Yes ◯ No

Ganglion or fibroma ◯ Yes ◯ No

Not sure ◯ Yes ◯ No

None of the above ◯ Yes ◯ No

Only answer question 10 if the growth was not located on the skin

Q10. Where was the site of the growth? ◯ Yes ◯ No

Breast ◯ Yes ◯ No

Kidney ◯ Yes ◯ No

Spine ◯ Yes ◯ No

Ovary ◯ Yes ◯ No

Testicular ◯ Yes ◯ No

Prostate ◯ Yes ◯ No

Other ◯ Yes ◯ No

Only answer questions 11 and 12 if the site of the growth was testicular

Q11. Has the growth ever been described as malignant or cancerous? ◯ Yes ◯ No

Q12. Was your testicular lump diagnosed as a variocele or hydrocele? ◯ Yes ◯ No

You only need to answer question 13 if you are not sure of the diagnosis, if the answer to question 10 was 'other' or you have not sought any medical advice.

Q13. Please describe this condition in your own words including: site of growth, name of the growth (if known), details of any treatment, follow ups or investigations

Q14. When your tumour was first found, had it spread to any other part of your body or lymph nodes? ◯ Yes ◯ No

Q15. Approximately when did you last have chemotherapy, radiotherapy or surgery for this condition?

Heartburn

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

Q1. Have you been told that your symptoms are complicated by or related to any of the following?

Ulcer	◯ Yes	◯ No
Barret's oesophagus	◯ Yes	◯ No
Oesophageal stricture or obstruction	◯ Yes	◯ No
Hiatus hernia	◯ 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 or hiatus hernia you do not need to complete anymore questions in this section

If the answer to question 1 is another condition, please tell us the name of the condition:

Q2. Have you seen a medical practitioner about these symptoms? ◯ Yes ◯ No

If the answer to question 2 is yes, please answer question 3:

Q3. Do any of the following apply to your symptoms in the last 12 months?

The symptoms started for the first time	◯ Yes	◯ No
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
None of these	◯ Yes	◯ No

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

Q5. 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 answer to question 1 or 3 is yes, you do not need to answer any more questions in this section.

Q6. Have you had or been asked to have a blood test in the last 3 months?

◯ Yes, for this condition ◯ Yes, for another condition ◯ No

If answer to question 6 is yes for this condition or no, you do not need to answer any more questions in this section.
If yes, for another condition please answer questions 7, 8 and 9.

Q7. Please tell us the name of the condition

Q8. When did you last have symptoms of this condition?

Q9. Please describe your symptoms including the severity, frequency and how long you have had them.

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 question 1 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 question 4 is yes, please answer questions 5-6. If no, skip to question 7

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 question 7 is yes, please answer questions 8-13. If no, skip to question 14

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 question 3 or 4 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 question 9. If it is yes (above 6.5), go to question 8 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 Question 9

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

Q9. Are you taking prescription medication for your cholesterol? ◯ Yes ◯ No

If you answered yes, please skip to question 11

Q10. Have you ever been prescribed or advised to take prescription medication for this? ◯ Yes ◯ No

If you answered no, please skip to question 12

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 question 13, you do not need to answer any more questions in this section.
If you answered No to qeuestion 13, 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?

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? ◯ 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 question 3 or 4 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 questions 7 to 9, otherwise skip to question 10

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 question 14

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

◯ Yes ◯ No

If you answered no to question 13 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 question 2 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 12 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

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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EDCO0906-0518