Health and Lifestyle Questionnaire

Adviser Reference

Please complete this form with as much information as possible about your health and lifestyle. The information needs to be as accurate as possible and may result in you receiving a higher income if you have certain health conditions or lifestyle factors.

If a condition does not apply to you, please leave that section blank.

- **If you are completing this form on a screen please ensure you save it regularly to ensure typed in information is not lost.**
- **If you are completing this form using a pen please use Black Ink and CAPITALS**

Once completed please return this form to your financial adviser.

Section 1 – Personal Details

Some of your personal information will be available from your pension provider and therefore we do not need to collect it here

All mandatory fields are marked with a *.

In boxes please select the correct answer or tick (✔) the correct answer if filling in by hand.

Title* ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other

Gender* ☐ Male ☐ Female

Surname*

Forename(s)*

Date of Birth D D M M Y Y

Nationality ☐ UK ☐ Other

Other

Marital status ☐ Single ☐ Married/Civil Partnership ☐ Separated ☐ Divorced ☐ Widowed

Occupation

Current occupation*

Current occupation basis* ☐ Full time ☐ Part time

If no longer working, previous occupation

Previous occupation end date M M Y Y Y Y

Contact Details

Country

Postcode

Section 2 – Medical Assessment

To be completed by you.

Please describe your health in as much detail as possible. All questions asked are relevant, and by providing full and correct information you will obtain as accurate a quotation as possible. Limited information may mean a fully guaranteed quote cannot be provided.

The quote will be based on the medical information supplied. However, independent verification of this information may be sought from a medical professional. If it is subsequently found that the questions were not answered accurately and with reasonable care or we are unable to confirm the information provided, then that could result in your income being reduced or your policy being cancelled.

Your details

Height* ☐ ft ☐ ins **or** ☐ cms

Weight* ☐ st ☐ lbs **or** ☐ kg

Waist measurement ☐ ins **or** ☐ cms

Smoking

Have you ever smoked?* ☐ Yes ☐ No

Do you currently smoke?* ☐ Yes ☐ No

When did you start?* ☐☐☐☐☐☐ (M M Y Y Y Y)

When did you stop?* ☐☐☐☐☐☐ (M M Y Y Y Y)

Have you been a regular daily smoker for the last 10 years?* ☐ Yes ☐ No

Cigarettes per day* ☐

Cigars per day* ☐

Rolling tobacco per week* ☐ ozs **or** ☐ gms

Pipe tobacco per week* ☐ ozs **or** ☐ gms

Drinking

How many units of alcohol do you drink weekly?* ☐

Medical Conditions

Do you have any medical conditions to disclose?* ☐ Yes ☐ No

If no, please return this form to your financial adviser.

If you have ever been diagnosed with any of the medical conditions detailed on the next page, please complete the relevant sections before returning it to your financial adviser.

Health and Lifestyle Questionnaire Sections

Please add Cancer/tumour name*

Please add any other medical conditions you have*

Section 3 – Medical Conditions

High blood pressure (Hypertension)

a) Date diagnosed M M Y Y Y Y

b) Last reading ____ SYS ____ DIA

c) Date of last reading[1] M M Y Y Y Y

d) Previous reading ____ SYS ____ DIA

e) Date of previous reading M M Y Y Y Y
(recommended if previous reading given)

Please list all the medication you CURRENTLY take for your High blood pressure (Hypertension)?

Medication name	Dose prescribed and unit e.g. grams, milligrams, micrograms, millilitres	Frequency e.g. daily, weekly or as required	Date commenced (MM/YYYY)
1			
2			
3			
4			
5			

Adviser Note: Once a medication has been selected, please press 'add medication' to complete the medication section

Please provide any further information you think may be important.

[1] **Guidance Note:**

Blood pressure readings required are those taken by your GP/Clinician rather than home self-testing kits

High cholesterol

a) Date diagnosed M M Y Y Y Y

b) Last reading _____ mmol/L

c) Date of last reading[2] M M Y Y Y Y

d) Previous reading _____ mmol/L

e) Date of previous reading M M Y Y Y Y

Please list all the medication you CURRENTLY take for your high cholesterol?

Medication name	Dose prescribed and unit e.g. grams, milligrams, micrograms, millilitres	Frequency e.g. daily, weekly or as required	Date commenced (MM/YYYY)
1			
2			
3			

Adviser Note: Once a medication has been selected, please press 'add medication' to complete the medication section

Please provide any further information you think may be important.

[2] Guidance Note:

Cholesterol readings required are those taken by your GP/Clinician rather than home self-testing kits

Heart condition – heart attack, angina and other heart conditions questionnaire

Please refer to any available hospital letters or reports about your heart condition to complete this section. You may also include copies of any reports with your request form.

Have you ever been diagnosed with any of the following?

Diagnosis	Date of diagnosis (MM/YYYY)	No. of occurrences	Condition ongoing? (yes/no)
Heart attack (Myocardial Infarction)			
Angina			
Heart failure			
Aortic aneurysm			
Cardiomyopathy			
Heart valve disorders			
Atrial fibrillation (AF)			
Other irregular heart rhythm			
Other: please specify (e.g. blocked artery)			

Are you currently under the care of a cardiologist? Yes ☐ No ☐ Last consultation date: M M Y Y Y Y

How many times have you been admitted to hospital due to your heart condition WITHIN THE PAST 10 YEARS?

Number of hospital admissions ☐ Date of last admission M M Y Y Y Y

Is any future treatment planned? Yes ☐ No ☐ If yes, please give details:

Please advise date and result of any STRESS (EXERCISE) ECG testing e.g. using a bicycle or treadmill.
(Do not include resting ECG tests.)

Date M M Y Y Y Y **Result:** Normal / Abnormal / Other **(Please delete as appropriate)**

If surgery has been carried out, please state type of procedure and date of MOST RECENT surgery.

Aortic valve replacement	☐	Successful?	☐ Yes	☐ No	Date M M Y Y Y Y
Mitral valve replacement	☐	Successful?	☐ Yes	☐ No	Date M M Y Y Y Y
Tricuspid valve replacement	☐	Successful?	☐ Yes	☐ No	Date M M Y Y Y Y
Pacemaker	☐	Successful?	☐ Yes	☐ No	Date M M Y Y Y Y
Cardioversion/ablation	☐	Successful?	☐ Yes	☐ No	Date M M Y Y Y Y
Aortic aneurysm repair	☐	Successful?	☐ Yes	☐ No	Date M M Y Y Y Y
Coronary artery bypass graft (CABG)	☐	Number of arteries treated	☐		Date M M Y Y Y Y
Coronary angioplasty/stents	☐	Number of arteries treated	☐		Date M M Y Y Y Y

What medication are you CURRENTLY taking? Please list all medication prescribed for your heart condition:

Medication name	Name of heart condition(s)	Dose prescribed and unit e.g. grams, milligrams, micrograms, millilitres	Frequency e.g. daily, weekly or as required	Date commenced (MM/YYYY)
1				
2				
3				
4				
5				

Adviser Note: Once a medication has been selected, please press 'add medication' to complete the medication section

Does your heart condition CURRENTLY affect you in any of the following ways?.

	Never	Some of the time	Most of the time	Always
Symptoms at rest	☐	☐	☐	☐
Breathlessness walking from room to room	☐	☐	☐	☐
Breathlessness climbing stairs	☐	☐	☐	☐
Chest pains on minor to moderate activity	☐	☐	☐	☐
Chest pains on severe exertion	☐	☐	☐	☐
Swollen ankles	☐	☐	☐	☐
Episodes of dizziness	☐	☐	☐	☐
Episodes of blackouts	☐	☐	☐	☐

Please provide any further information you think may be important (e.g. dates of multiple surgery)

Diabetes questionnaire

Please refer to any available hospital letters or reports about your diabetes to complete this section. You may also include copies of any reports with your request form.

When was your diabetes diagnosed? M M Y Y Y Y

Is your diabetes? ☐ Type 1 ☐ Type 2

How is your diabetes controlled? ☐ Diet only ☐ Non-insulin (tablet) ☐ Insulin

If you monitor your own blood glucose levels how frequently do you monitor it? Number of times ☐

Frequency (please tick as appropriate)

☐ Daily ☐ Weekly ☐ Fortnightly ☐ Four weeks ☐ Monthly ☐ Quarterly ☐ Half–yearly ☐ Annually

Please give readings for HbA1c: (Please record readings either as mmol/mol or as a percentage)

Guidance Note:

HbA1c readings can be reported as mmol/mol or as a percentage. Mmol/mol readings are usually higher figures between 40 mmol/mol and 140+ mmol/mol; whereas percentage readings are usually lower figures between 3.0% and 16.0%. (Please do not advise results of glucose finger prick tests, fasting blood sugar tests or random blood sugar tests here.)

How many HbA1c readings are available (1 or 2)? ☐

HbA1c Reading 1 DCCT (%) or IFFC (mmol/mol) Date M M Y Y Y Y

HbA1c Reading 2 DCCT (%) or IFFC (mmol/mol) Date M M Y Y Y Y

Please list all the medication you CURRENTLY take for your diabetes?

Medication name	Dose prescribed and unit e.g. grams, milligrams, micrograms, millilitres	Frequency e.g. daily, weekly or as required	Date commenced (MM/YYYY)
1			
2			
3			
4			
5			

Adviser Note: Once a medication has been selected, please press 'add medication' to complete the medication section

Have you ever been admitted into hospital as a result of your diabetes? Yes ☐ No ☐

If yes, when were you last hospitalised? Date M M Y Y Y Y

Do you suffer from any of the following diabetic complications? If yes, please select as appropriate giving details with dates in the box provided below.

☐ Heart disease

☐ Retinopathy (excluding other eye disease)

☐ Neuropathy

☐ Kidney disease (protein in urine)

☐ Peripheral vascular disease (with ulceration)

☐ Amputation

Please provide any further information you think may be important.

Stroke questionnaire

Please refer to any available hospital letters or reports about your stroke(s) to complete this section. You may also include copies of any reports with your request form.

Please advise which of the following you have been diagnosed with and give details of all episodes below:

Episode/type (e.g.CVA, TIA)	Date of Diagnosis (MM/YYYY)	Part of body affected	Duration of symptoms (years, months or days)	Duration until full recovery (years, months or days)

Please advise of any of the following ongoing problems due to your stroke:

☐ Speech difficulties

☐ Vision impairment

☐ Arm paralysis

☐ Leg paralysis

☐ Short-term memory loss

Are you still under follow up? Yes ☐ No ☐

What medication are you CURRENTLY taking for this condition?

Medication name	Dose prescribed and unit e.g. grams, milligrams, micrograms, millilitres	Frequency e.g. daily, weekly or as required	Date commenced (MM/YYYY)
1			
2			
3			

Adviser Note: Once a medication has been selected, please press ‘add medication’ to complete the medication section

Please provide any further information you think may be important.

Please also complete the activities of daily living questionnaire on page 16

Respiratory/lung disease questionnaire

Please refer to any available hospital letters or reports about your respiratory or lung disease condition to complete this section. You may also include copies of any reports with your request form.

Please advise which of the following respiratory conditions you have been diagnosed with:

Date of diagnosis:

- ☐ Chronic obstructive airways/pulmonary disease (COAD/COPD) — M M Y Y Y Y
- ☐ Emphysema — M M Y Y Y Y
- ☐ Bronchiectasis — M M Y Y Y Y
- ☐ Pneumoconiosis (a type of lung disease related to occupation) — M M Y Y Y Y
- ☐ Asbestosis — M M Y Y Y Y
- ☐ Asthma — M M Y Y Y Y
- ☐ Pleural plaques — M M Y Y Y Y
- ☐ Sleep apnoea — M M Y Y Y Y
- ☐ Other — Please specify _____ — M M Y Y Y Y

What medications are you currently taking for this condition?

Medication name	Dose prescribed and unit e.g. grams, milligrams, micrograms, millilitres	Frequency e.g. daily, weekly or as required	Date commenced (MM/YYYY)
1			
2			
3			
4			
5			

Adviser Note: Once a medication has been selected, please press 'add medication' to complete the medication section

If you have been admitted to hospital for your respiratory/lung disease, how many times have you been admitted and please indicate date of last admission?

Number of hospital admissions ☐ Date of last admission M M Y Y Y Y

How has your lung function been graded according to FEV1? (This does not refer to Peak Flow):

- Unaffected — ☐ Yes ☐ No
- Minimally impaired (FEV1 greater than 70%) — ☐ Yes ☐ No
- Moderately impaired (FEV1 50-70%) — ☐ Yes ☐ No
- Severely impaired (FEV1 less than 50%) — ☐ Yes ☐ No

Do any of the following apply due to your respiratory lung condition?	Never	Some of the time	Most of the time	Always
Chest infections	☐	☐	☐	☐
Need for home oxygen	☐	☐	☐	☐
Need for a continuous positive airway pressure (CPAP) breathing machine	☐	☐	☐	☐
Signs of cor pulmonale (right heart failure due to lung disease)	☐	☐	☐	☐
Breathlessness walking from room to room	☐	☐	☐	☐
Breathlessness climbing stairs	☐	☐	☐	☐
Breathlessness when lying flat	☐	☐	☐	☐
Oral steroids (in tablet form only e.g. Prednisolone)	☐	☐	☐	☐

Please provide any further information you think may be important.

Multiple sclerosis questionnaire

Please refer to any available hospital letters or reports about your multiple sclerosis to complete this section. You may also include copies of any reports with your request form.

When was your multiple sclerosis diagnosed? M M Y Y Y Y

What is your multiple sclerosis sub-type?

☐ Relapsing remitting

☐ Secondary progressive

☐ Primary progressive

☐ Progressive relapsing

Please advise number of attacks in the last 5 years: ☐

If you have been admitted to hospital due to your multiple sclerosis, please indicate how many times you have been admitted and the date of your last admission?

Number of hospital admissions ☐ Date of last admission M M Y Y Y Y

What medication are you CURRENTLY taking?

Medication name	Dose prescribed and unit e.g. grams, milligrams, micrograms, millilitres	Frequency e.g. daily, weekly or as required	Date commenced (MM/YYYY)
1			
2			
3			
4			
5			

Adviser Note: Once a medication has been selected, please press 'add medication' to complete the medication section

Do you have, or have you had, any of the following in relation to your multiple sclerosis?

Bladder incontinence/self-catheterisation	☐ Yes	☐ No
Secondary infection (e.g. pneumonia)	☐ Yes	☐ No
Progressive mental deterioration	☐ Yes	☐ No
Vision impairment	☐ Yes	☐ No
Speech impairment	☐ Yes	☐ No
Paralysis of a limb	☐ Yes	☐ No
Use of steroids (e.g. Prednisolone) on more than 1 occasion	☐ Yes	☐ No

Please also complete the activities of daily living questionnaire on page 16

Please provide any further information you think may be important.

Other neurological disease questionnaire

Please refer to any available hospital letters or reports about your other neurological conditions to complete this section. You may also include copies of any reports with your request form.

Please advise which of the following you have been diagnosed with:

☐ Senile dementia — Date of diagnosis: M M Y Y Y Y

☐ Vascular dementia — Date of diagnosis: M M Y Y Y Y

☐ Alzheimer's disease — Date of diagnosis: M M Y Y Y Y

☐ Parkinson's disease — Date of diagnosis: M M Y Y Y Y

☐ Motor neurone disease — Date of diagnosis: M M Y Y Y Y

☐ Other Please specify _____ — Date of diagnosis: M M Y Y Y Y

What medication are you CURRENTLY taking in relation to your neurological condition?

Medication name	Name of condition(s)	Dose prescribed and unit e.g. grams, milligrams, micrograms, millilitres	Frequency e.g. daily, weekly or as required	Date commenced (MM/YYYY)
1				
2				
3				
4				
5				

Adviser Note: Once a medication has been selected, please press 'add medication' to complete the medication section

If you have been admitted to hospital for your neurological condition, how many times have you been admitted?

Number of hospital admissions _____ Date of last admission M M Y Y Y Y

Please advise last MMSE (Mini Mental State Examination) score if known _____/30

Do you have, or have you had, any of the following symptoms in relation to your neurological condition?

Pressure sores ☐ Yes ☐ No

Falls ☐ Yes ☐ No

Tremors ☐ Yes ☐ No

Seizures ☐ Yes ☐ No

Please provide any further information you think may be important, e.g. the result of any cognition assessment.

Please also complete the activities of daily living questionnaire on page 16

Activities of daily living (ADL) Questionnaire

Please advise relevant diagnosis in relation to which you are completing this questionnaire:

Please tick one box from each of the following that most closely reflects your current condition.

Dressing: How is your ability to dress yourself?

- ☐ I require full assistance to dress myself
- ☐ I am able to dress myself but require some assistance with buttons, zips and laces etc.
- ☐ I am able to fully dress myself (including buttons, zips, laces etc.)

Mobility indoors: How easily you can move from one place to another?

- ☐ I am bedridden
- ☐ I require full assistance of one or two people
- ☐ I use a wheelchair always
- ☐ I use a wheelchair some of the time
- ☐ I walk with assistance (frame/stick/rolling walker)
- ☐ I can independently move from one place to another

Transferring: How well are you able to move from one position to another, e.g. from a chair to a bed?

- ☐ I am unable to transfer and have no sitting ability
- ☐ I require major help to get into a chair or bed
- ☐ I require minor help to get into a chair or bed but can sit unaided
- ☐ I am able to get into a chair or bed independently

Bladder control: How would you describe your current bladder control?

- ☐ I am unable to control my bladder or I am catheterised
- ☐ I have occasional accidents (once a week)
- ☐ I am in full control of my bladder (continent)

Bowel control: How would you describe your current bowel control?

- ☐ I have no control of my bowel movements (incontinent or require an enema)
- ☐ I have occasional accidents (once a week)
- ☐ I am in full control of my bowel movements (continent)

Bathing and showering: How easy is it for you to bathe and get in and out of the bath or shower?

- ☐ I require full assistance to bathe or shower (dependent)
- ☐ I can wash independently but require some assistance in and out of the bath or shower
- ☐ I can independently wash and bathe myself

Feeding: What is your current ability to feed yourself once food has been prepared and made available?

- ☐ I am unable to feed myself or require a naso-gastric tube/PEG tube
- ☐ I require assistance to cut up the food on my plate but I am able to feed myself
- ☐ I can independently feed myself

How has your ability to perform your ADL changed over the last 5 years?

- ☐ I have experienced minimal to no change
- ☐ I have experienced deterioration in two or more activities of daily living
- ☐ I have experienced rapid deterioration

Cancer, leukaemia, lymphoma, growth or tumour questionnaire

Please refer to any available hospital letters or reports about your cancer, stage, grade and treatment received to complete this section. You may also include copies of any reports with your request form.

Where is the tumour located? ☐

When was the tumour/malignant condition first diagnosed? ☐☐☐☐☐☐ (M M Y Y Y Y)

Was the tumour: ☐ Benign ☐ Pre-cancerous ☐ Malignant

Do you know the clinically confirmed grade of the tumour? ☐ Yes ☐ No

If yes, please tick appropriate option ☐ Grade 1 (Low) ☐ Grade 2 (Intermediate) ☐ Grade 3 (High)

Do you know the staging? If you know the clinically confirmed staging of the tumour, please tick and provide details against the relevant classification below:

What type of tumour staging is? (Please complete the appropriate staging below)

General cancer staging classification (used for all cancers e.g. Stage 1B):

Stage: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 Sub-stage (1-4 only) ☐ a ☐ b ☐ c

TNM (commonly used for most cancers e.g. T1aN0M0)

T Stage: ☐ Ta ☐ Tis ☐ T0 ☐ T1 ☐ T2 ☐ T3 ☐ T4 ☐ TX Sub-stage (T1-T4 only) ☐ a ☐ b ☐ c

N Stage: ☐ N0 ☐ N1 ☐ N2 ☐ N3 ☐ Nx Sub-stage (N1-N3 only) ☐ a ☐ b ☐ c

M Stage: ☐ M0 ☐ M1 ☐ Mx

Dukes classification (used for colorectal cancers)

Stage: ☐ A ☐ B ☐ C ☐ D

Modified Astler-Coller (MAC) (used for colorectal cancers):

Stage: ☐ A1 ☐ A2 ☐ A3 ☐ B1 ☐ B2 ☐ B3 ☐ C1 ☐ C2 ☐ C3 ☐ D1 ☐ D2 ☐ D3

Figo classification (used for gynaecological cancers)

Stage: ☐ 1 ☐ 2 ☐ 3 ☐ 4

Clark level (used for skin cancers, specifically malignant melanomas)

Stage: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Breslow thickness (used for skin cancers, specifically malignant melanomas)

Details: ☐ mm

Ann Arbor classification (used for lymphomas)

Stage: ☐ 1 ☐ 2 ☐ 3 ☐ 4

Please tick the box that most closely describes the nature of the tumour.

☐ Carcinoma-in-situ (stage O, Tis, Ta)

☐ Only local tumour growth

☐ Tumour invaded adjacent distant lymph nodes
If ticked, please advise number of nodes affected and location

☐ Tumour invaded distant lymph nodes
If ticked, please advise number of nodes affected and location

☐ Tumour spread to distant organs (distant metastases) If so, where?

Guidance Note:

The removal of lymph nodes for biopsy does not necessarily mean the cancer has spread there.

Has there been a recurrence? ☐ Yes ☐ No

Recurrence date M M Y Y Y Y

Have you been discharged? ☐ Yes ☐ No

In the case of PROSTATE CANCER, please advise where known

If your condition is a type of prostate cancer, please provide the following information if known:

		Date recorded:
Current prostate specific antigen (PSA) level		M M Y Y Y Y
Pre-treatment PSA level		M M Y Y Y Y
Gleason score		M M Y Y Y Y

In the case of BREAST CANCER, please advise where known

Breast cancer hormone receptor status

What medication are you CURRENTLY taking for this condition?

Medication name	Dose prescribed and unit e.g. grams, milligrams, micrograms, millilitres	Frequency e.g. daily, weekly or as required	Date commenced (MM/YYYY)
1			
2			
3			

Adviser Note: Once a medication has been selected, please press ‘add medication’ to complete the medication section

Did you have, or are you due to have, any of the following as a result of your tumour or malignant condition:

☐ Surgery Type of surgery: Date: M M Y Y Y Y

☐ Chemotherapy Date commenced: M M Y Y Y Y Date ended: M M Y Y Y Y

☐ Radiotherapy (including brachytherapy) Date commenced: M M Y Y Y Y Date ended: M M Y Y Y Y

☐ Bone marrow/stem cell transplant Date commenced: M M Y Y Y Y Date ended: M M Y Y Y Y

☐ Hormone therapy Date commenced: M M Y Y Y Y Date ended: M M Y Y Y Y

☐ Other (Please give full details in box below) Date commenced: M M Y Y Y Y Date ended: M M Y Y Y Y

Description
(e.g. BCG, HIFU, Immunotherapy)

Other conditions

Condition one - Please specify the condition.

When were you first diagnosed with this condition?* M M Y Y Y Y

When did you last experience symptoms for this condition?* M M Y Y Y Y

When did you last receive medication/treatment for this condition? M M Y Y Y Y

How many times have you been hospitalised for this condition? 0-99

When were you last admitted to hospital for this condition? M M Y Y Y Y

Treatments

Have you received any treatments within the past 5 years? ☐ **Yes** ☐ **No**

Did you receive any of the following treatments:

Renal dialysis ☐ Yes ☐ No

Surgery ☐ Yes ☐ No

Surgery type

Medication name	Dose prescribed and unit e.g. grams, milligrams, micrograms, millilitres	Frequency e.g. daily, weekly or as required
1		
2		
3		
4		
5		

Adviser Note: Once a medication has been selected, please press 'add medication' to complete the medication section

Condition two - Please specify the condition.

When were you first diagnosed with this condition?* M M Y Y Y Y

When did you last experience symptoms for this condition?* M M Y Y Y Y

When did you last receive medication/treatment for this condition? M M Y Y Y Y

How many times have you been hospitalised for this condition? 0-99

When were you last admitted to hospital for this condition? M M Y Y Y Y

Treatments

Have you received any treatments within the past 5 years? ☐ **Yes** ☐ **No**

Did you receive any of the following treatments:

Renal dialysis ☐ Yes ☐ No

Surgery ☐ Yes ☐ No

Surgery type

Medication name	Dose prescribed and unit e.g. grams, milligrams, micrograms, millilitres	Frequency e.g. daily, weekly or as required
1		
2		
3		
4		
5		

Adviser Note: Once a medication has been selected, please press 'add medication' to complete the medication section

Condition three - Please specify the condition.

When were you first diagnosed with this condition?* M M Y Y Y Y

When did you last experience symptoms for this condition?* M M Y Y Y Y

When did you last receive medication/treatment for this condition? M M Y Y Y Y

How many times have you been hospitalised for this condition? 0-99

When were you last admitted to hospital for this condition? M M Y Y Y Y

Treatments

Have you received any treatments within the past 5 years? ☐ Yes ☐ No

Did you receive any of the following treatments:

Renal dialysis ☐ Yes ☐ No

Surgery ☐ Yes ☐ No

Surgery type

Medication name	Dose prescribed and unit e.g. grams, milligrams, micrograms, millilitres	Frequency e.g. daily, weekly or as required
1		
2		
3		
4		
5		

Adviser Note: Once a medication has been selected, please press 'add medication' to complete the medication section

Please return this form to your financial adviser