TITLE         FORENAME         SURNAME         Central           DATE OF BIRTH		Portman
DATE OF BIRTH           ADDRESS           POSITCODE         TELNO.           WORK TEL.         MOBILE.           EMAIL ADDRESS         YES/NO           POCTORS NAME AND ADDRESS         YES/NO           I.Do you suffer from isplit loss?         YES/NO           2.Do you suffer from sight loss?         YES/NO           3.Do you suffer from sight loss?         YES/NO           4.How many units of alcohol do you drink in the average week?		
DDRESS         Intervention           POSIT CODE         TEL NO.           WORK TEL         MOBILE.           EMAIL ADDRESS         DOCTORS NAME AND ADDRESS           IP YOLANSWER VES TO ANY OF THE OUTSTIONS BELOW, PLEASE GIVE DETAILS. (cc. medication name):         11.0 you suiffer from sight loss?           2.Do you suffer from sight loss?         YES/NO           2.Do you suffer from sight loss?         YES/NO           4.How many units of alcohol do you drink in the average week?         (a unit is 'A pain of lager, a single measure of spirits or a small glass of wine)           5.Do you snoke any tobacco products? Yes (how many daily)         YES/NO           7.Do you use recreational drugs?         YES/NO           8.Are you or could you be pregnan? Due date         YES/NO           9.Do you currently treeving or wating for any treatment from a hospital or clinic?         YES/NO           10.Are you currently taking any medications or drugs which are prescribed, bought over the counter or recreational?         YES/NO           11.Are you currently taking any medications related to your circulation e.g.         YES/NO           12.Have you ever had any medical conditions related to your circulation e.g.         YES/NO           13.Have you ever had any medical conditions related to your circulation e.g.         YES/NO           14.Have you ever had any medical conditions related to your nervous system e.g. Fits         YES/NO		
Image: Post Cobe         TEL. NO.           WORK TEL.         MOBILE.           EMAIL ADDRESS         VES/NO           DOCTORS: NAME AND ADDRESS         YES/NO           I.De you suffer from hearing loss?         YES/NO           J.Do you suffer from sight loss?         YES/NO           Allow many units of alcohol do you drink in the average week?         YES/NO           (a unit is ½ a pint of lager, a single measure of spirits or a small glass of wine)         YES/NO           S.Do you sende any tobacco products? Yes (how many daily)         YES/NO           9.Do you currently taking any medications or drugs which are prescribed.         YES/NO           9.Do you currently receiving or waiting for any treatment from a hospital or clinic?         YES/NO           11.Ave you ever had any medical conditions related to your ireutation e.g.         YES/NO           12.Have you ever had any medical conditions related to your ireutation e.g.         YES/NO           13.Have you ever had any medical conditions related to your ireutation e.g.         YES/NO           14.Have you ever had any medical conditions related to your breath, peumonia, persistent cough         YES/NO           16.Have you ever had a		
WORK TEL         MOBILE.           DOCTORS NAME AND ADDRESS         Productors NAME AND ADDRESS           PYOL ANSWER VES TO ANY OF THE OUESTIONS BELOW, PLEASE GIVE DETAILS, (ee. medication name).         1.Do you suffer from haring loss?         YES/NO           2. Do you suffer from haring loss?         YES/NO         YES/NO           4. How many units of alcohol do you drink in the average week?         YES/NO         YES/NO           4. How many units of alcohol do you drink in the average week?         YES/NO         YES/NO           5. Do you sure entrop a single measure of spirits or a small glass of winc)         YES/NO         YES/NO           9. Do you currently taking any medical conditions related to your provide spiral or clinic?         YES/NO         YES/NO           9. Do you currently taking any medical conditions related to your heart e.g.         YES/NO         YES/NO           10. Are you currently taking any medical conditions related to your heart e.g.         YES/NO         YES/NO           11. Are you ever had any medical conditions related to your provide year gasthma or YES/NO         YES/NO         YES/NO           12. Have you ever had any medical conditions related to your provide gasthma or YES/NO         YES/NO         YES/NO           13. Have you ever had any medical conditions related to your provide year gasthma or YES/NO         YES/NO         YES/NO           14. Have you ever had any medical conditions relat		
Image: Second State State         Second State State           DOCTORS NAME AND ADDRESS         YES/NO           1 Do you suffer from hearing loss?         YES/NO           2. Do you suffer from sight loss?         YES/NO           3. Do you suffer from sight loss?         YES/NO           4. How many units of alcohol do you drink in the average week?         YES/NO           (a unit is ½ a pint of lager, a single measure of spirits or a small glass of wine)         YES/NO           5. Do you suce any tobacco products? YES (so thow many daily)         YES/NO           6. Are you or could you be pregnant? Due date         YES/NO           9. Do you currently taking any medications or drags which are prescribed, bought over the counter or recreational?         YES/NO           10. Are you currently taking any medications related to your circulation c.g.         YES/NO           10. Are you currently taking any medications related to your bart e.g.         YES/NO           10. Are you currently taking any medications related to your circulation c.g.         YES/NO           11. Are you ever had any medical conditions related to your circulation c.g.         YES/NO           12. Have you ever had any medical conditions related to your strancin almunity problem.         14. Have you ever had any medical conditions related to your strancin almunity problem.           14. Have you ever had any medical conditions related to your brent e.g. Fits         YES/NO <td></td> <td></td>		
DOCTORS NAME AND ADDRESS         VESINO           11 Do you suffer from hearing loss?         VES/NO           2. Do you suffer from hearing loss?         VES/NO           2. Do you suffer from hearing loss?         VES/NO           3. Do you suffer from hearing loss?         VES/NO           4. How many units of alcohol do you drink in the average week?         VES/NO           (a unit is ½ apint of lager, a single measure of spirits or a small glass of wine)         VES/NO           5. Do you snoke any tobacco products? Yes (how many daily)         VES/NO           7. Do you use recreational drugs?         VES/NO           8. Are you or could you be pregnant? Due date         VES/NO           9. Do you currently taking any medications or drugs which are prescribed.         VES/NO           10. Are you currently taking any medications related to your heart e.g.         VES/NO           10. Are you currently taking any medications related to your blood e.g. anaemia, neurysm         14. Have you ever had any medical conditions related to your blood e.g. anaemia, persistent cough           11. Have you ever had any medical conditions related to your blood e.g. anaemia, persistent cough         VES/NO           12. Have you ever had any medical conditions related to your blood e.g. anaemia, persistent cough         14. Have you ever had any medical conditions related to your nervous system c.g. Fits         YES/NO           13. Have you ever had any medical conditions		
I Do you suffer from haring loss?       VES/NO         2. Do you suffer from night loss?       VES/NO         3. Do you have mobility problems?       VES/NO         4. How many units of alcohol do you drink in the average week?		
2. Do you suffer from sight loss?       YES.NO         3. Do you have mobility problems?       YES.NO         4. How many units of alcohol do you drink in the average week?       YES.NO         (a unit is ½ a pint of lager, a single measure of spirits or a small glass of wine)       YES.NO         5. Do you smoke any tobacco products? Yes (how many daily)       YES.NO         6. Do you cerve tobacco, pan, gutkha or supari?       YES.NO         7. Do you ucerently have, or recovered from, any form of cancer?       YES.NO         9. Do you eurently taking any medications or drugs which are prescribed, bought over the counter or recreational?       YES.NO         10. Are you currently taking any medical conditions related to your heart e.g.       YES.NO         11. Are you ever had any medical conditions related to your bolis, numery amblis, persense in thormobacito, numery amblis, numery amblis, numery amblis, numery amblis, numery amblis, persense in thormobacito, numery amblis, numery amblis, numery amblis, numery amblis, amblis, persense in thormobacito, numery amblis, numery amblis	IF YOU ANSWER YES TO ANY OF THE QUESTIONS BELOW, PLEASE GIVE DETAILS. (eg. medicatio	<u>n name)</u>
3.Do you have mobility problems?       YES/NO         4.How many units of alcohol do you drink in the average week?	1.Do you suffer from hearing loss?	YES/NO
<ul> <li>4.How many units of alcohol do you drink in the average week?</li> <li>(a unit is ½ a pint of lager, a single measure of spirits or a small glass of wine)</li> <li>5.Do you smoke any tobacco products? Yes (how many daily)</li> <li>6.Do you smoke any tobacco products? Yes (how many daily)</li> <li>7.Do you use recreational drugs?</li> <li>7.VES/NO</li> <li>8.Are you or could you be pregnant? Due date</li> <li>7.YES/NO</li> <li>9.Do you currently neceving or waiting for any treatment from a hospital or clinic?</li> <li>7.YES/NO</li> <li>9.Do you currently taking any medications or drugs which are prescribed,</li> <li>7.YES/NO</li> <li>10. Are you currently receiving or waiting for any treatment from a hospital or clinic?</li> <li>7.YES/NO</li> <li>11. Are you currently receiving or waiting for any treatment from a hospital or clinic?</li> <li>7.YES/NO</li> <li>11. Are you ever had any medicat conditions related to your clinuation e.g.</li> <li>7.YES/NO</li> <li>12. Have you ever had any medical conditions related to your breat e.g.</li> <li>9. YES/NO</li> <li>13. Have you ever had any medical conditions related to your broathing e.g asthma or</li> <li>7.YES/NO</li> <li>14. Have you ever had any medical conditions related to your broathing e.g asthma or</li> <li>7. YES/NO</li> <li>7. Brave you ever had any medical conditions related to your broathing e.g asthma or</li> <li>7. YES/NO</li> <li>7. Have you ever had any medical conditions related to your broath, pneumonia, persistent cough</li> <li>16. Have you ever had any medical conditions related to your broath, pneumonia, persistent cough</li> <li>17. Have you ever had any medical conditions related to your broath, pneumonia, persistent cough</li> <li>18. Have you ever had any medical conditions related to your broath, pneumonia, persistent cough</li> <li>19. Have you ever had any medical conditions related to your broath, pneumonia, persistent cough</li> <li>19. Have you ever had any medical conditions related to your since e.g. Hepatitis,</li> <li>7. Y</li></ul>		
(a unit is ½ a pint of lager, a single measure of spirits or a small glass of wine)       YES/NO         5.Do you smoke any tobacco products? Yes (how many daily)       YES/NO         6.Do you chew tobacco, pan, gutkha or supari?       YES/NO         7.Do you use recreational drugs?       YES/NO         9.Do you currently have, or recovered from, any form of cancer?       YES/NO         10. Are you currently receiving or waiting for any treatment from a hospital or clinic?       YES/NO         11. Are you currently taking any medical conditions related to your heart e.g.       YES/NO         bought over the counter or recreational?       YES/NO         12. Have you ever had any medical conditions related to your circulation e.g.       YES/NO         Blood pressure, high cholesterol, deep vein thrombosis, pulmonary embolism, aneurysm       YES/NO         14. Have you ever had any medical conditions related to your relaulation, g.g. atsima or       YES/NO         15. Have you ever had any medical conditions related to your streath, pacemonia, persistent cough       YES/NO         16. Have you ever had any medical conditions related to your streate, g.s. Atsima or       YES/NO         17. Have you ever had any medical conditions related to your streath, percomonia, persistent cough       YES/NO         16. Have you ever had any medical conditions related to your streath, percomonia, persistent cough       YES/NO         16. Have you ever had any medical conditions rela		YES/NO
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7.Do you use recreational drugs?       YES/NO         8.Are you or could you be pregnant? Due date		
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bought over the counter or recreational?       YES/NO         leart attack, angina, replacement valve, stent, pacemaker, heart murmur, infective endocarditis, congenital defects, transplant.       YES/NO         13. Have you ever had any medical conditions related to your blood e.g. anaemia, prolonged bleeding following injury, surgery, or tooth extraction, immunity problem.       YES/NO         14. Have you ever had any medical conditions related to your blood e.g. anaemia, persistent cough prolonged bleeding following injury, surgery, or tooth extraction, immunity problem.       YES/NO         15. Have you ever had any medical conditions related to your stenathing e.g asthma or YES/NO Chronic airway disease, sleep apnoea, bronchitis, shortness of breath, pneumonia, persistent cough       YES/NO         16. Have you ever had any medical conditions related to your stomach and digestion e.g reflux, YES/NO or blackouts (e.g. epilepsy), stroke, dementia, Parkinson's Disease, Multiple sclerosis       YES/NO         17. Have you ever had any medical conditions related to your genital or urinary e.g. Kishey disease, prostate problems, gynaecological problems       YES/NO         19. Have you ever had any medical conditions related to your stomes e.g diabetes, YES/NO       YES/NO         14. Have you ever had any medical conditions related to your shore e.g. diabetes, YES/NO       YES/NO         19. Have you ever had any medical conditions related to your shore e.g. diabetes, YES/NO       YES/NO         19. Have you ever had any medical conditions related to your shore e.g. diabetes, YES/NO       YES/NO <t< td=""><td></td><td></td></t<>		
12. Have you ever had any medical conditions related to your heart e.g.       YES/NO         heart attack, angina, replacement valve, stent, pacemaker, heart murmur, infective endocarditis, congenital defects, transplant.       YES/NO         13. Have you ever had any medical conditions related to your circulation e.g.       YES/NO         Blood pressure, high cholesterol, deep vein thrombosis, pulmonary embolism, aneurysm       YES/NO         14. Have you ever had any medical conditions related to your blood e.g. anæmia, presistent cough       YES/NO         16. Have you ever had any medical conditions related to your breath, pneumonia, persistent cough       YES/NO         16. Have you ever had any medical conditions related to your stomach and digestion e.g. Fits       YES/NO         or blackouts (e.g. epilepsy), stroke, dementia, Parkinson's Disease, Multiple sclerosis       YES/NO         17. Have you ever had any medical conditions related to your liver e.g. Hepatitis, YES/NO       YES/NO         Indigestion, ulcers, ulcerative colitis, Crohn's Disease.       YES/NO         19. Have you ever had any medical conditions related to your perital or urinary e.g.       YES/NO         Kidney disease, prostate problems, gynaacological problems       YES/NO         19. Have you ever had any medical conditions related to your bones or joints e.g. Osteoporosis, YES/NO       YES/NO         Thyroid problems, Addison's disease       YES/NO       YES/NO         20. Have you ever had any medical condi		
heart attack, angina, replacement valve, stent, pacemaker, heart murmur, infective endocarditis, congenital defects, transplant.YES/NO13. Have you ever had any medical conditions related to your blood e.g. anaemia, prolonged bleeding following injury, surgery, or tooth extraction, immunity problem.YES/NO14. Have you ever had any medical conditions related to your breathing e.g asthma or Chronic airway disease, sleep apnoea, bronchitis, shortness of breath, pneumonia, persistent coughYES/NO16. Have you ever had any medical conditions related to your stomating e.g. asthma or or blackouts (e.g. epilepsy), stroke, dementia, Parkinson's Disease, Multiple sclerosisYES/NO17. Have you ever had any medical conditions related to your liver e.g. Hepatitis, Jaudice, cirrhosis, fatty liver disease, transplantYES/NO19. Have you ever had any medical conditions related to your genital or urinary e.g Kidney disease, prostate problems, gynaecological problemsYES/NO20. Have you ever had any medical conditions related to your bornes e.g diabetes, Thyroid problems, Addison's diseaseYES/NO21. Have you ever had any medical conditions related to your bornes e.g. diabetes, Kidney disease, prostate problems, gynaecological problemsYES/NO21. Have you ever had any medical conditions related to your shones e.g. diabetes, Thyroid problems, Addison's diseaseYES/NO21. Have you ever had any medical conditions related to your shones e.g. diabetes, Thyroid problems, Addison's diseaseYES/NO21. Have you ever had any medical conditions related to your shones e.g. diabetes, Steree and any medical conditions related to your shones e.g. diabetes, Thyroid problems, Addison's diseaseYES/NO21. Have y		YES/NO
<ul> <li>infective endocarditis, congenital defects, transplant.</li> <li>13. Have you ever had any medical conditions related to your circulation e.g. YES/NO</li> <li>Blood pressure, high cholesterol, deep vein thrombosis, pulmonary embolism, aneurysm</li> <li>14. Have you ever had any medical conditions related to your blood e.g. anaemia, YES/NO</li> <li>prolonged bleeding following injury, surgery, or tooth extraction, immunity problem.</li> <li>15. Have you ever had any medical conditions related to your breathing e.g. astama or YES/NO</li> <li>Chronic airway disease, sleep apnoea, bronchitis, shortness of breath, pneumonia, persistent cough</li> <li>16. Have you ever had any medical conditions related to your stomach and digestion e.g. reflux, YES/NO</li> <li>or blackouts (e.g. epilepsy), stroke, dementia, Parkinson's Disease, Multiple sclerosis</li> <li>17. Have you ever had any medical conditions related to your genital or urinary e.g.</li> <li>YES/NO</li> <li>Jundice, cirrhosis, fatty liver disease, transplant</li> <li>19. Have you ever had any medical conditions related to your penital or urinary e.g.</li> <li>YES/NO</li> <li>Kidney disease, prostate problems, gynaecological problems</li> <li>20. Have you ever had any medical conditions related to your bones or joints e.g. Osteoporosis, YES/NO</li> <li>arthritis, replacement joints, osteogenesis imperfecta, receive bisphosphonate therapy</li> <li>21. Have you ever had any medical conditions related to your skin e.g. cozema, psoriasis, other skin conditions</li> <li>21. Have you ever had any medical conditions related to your family (genetic)</li> <li>YES/NO</li> <li>illness e.g sickle cell anaemia, thalassemia, haemophilia, cleft lip/palate</li> <li>24. Have you ever had any medical conditions related to allergies e.g. to medicines, periasiti, other skin conditions</li> <li>23. Have you ever had any medical conditions related to allergies e.g. to medicines, periasiti, other skin conditions</li> <li>24. Have you ever had any medical conditions related t</li></ul>		
<ul> <li>13.Have you ever had any medical conditions related to your circulation e.g. YES/NO Blood pressure, high cholesterol, deep vein thrombosis, pulmonary embolism, aneurysm</li> <li>14.Have you ever had any medical conditions related to your blood e.g. anaemia, YES/NO prolonged bleeding following injury, surgery, or tooth extraction, immunity problem.</li> <li>15. Have you ever had any medical conditions related to your nervous system e.g. Fits YES/NO or blackouts (e.g. epilepsy), stroke, dementia, Parkinson's Disease, Multiple sclerosis</li> <li>17.Have you ever had any medical conditions related to your nervous system e.g. Fits YES/NO indigestion, ulcers, ulcerative colitis, Crohn's Disease.</li> <li>18.Have you ever had any medical conditions related to your genital or urinary e.g Kidney disease, prostate problems, gynaecological problems</li> <li>20.Have you ever had any medical conditions related to your bones or joints e.g. Osteoporosis, YES/NO Kidney disease, prostate problems, gynaecological problems</li> <li>21.Have you ever had any medical conditions related to your bones or joints e.g. Osteoporosis, YES/NO arthritis, replacement joints, osteogenesis imperfecta, receive bisphosphonate therapy</li> <li>21.Have you ever had any medical conditions related to your family (genetic) illness e.g sickle cell anaemia, thalassemia, haemophilia, cleft lip/palate</li> <li>24.Have you ever had any medical conditions related to your family (genetic) illness e.g sickle cell anaemia, thalassemia, haemophilia, cleft lip/palate</li> <li>24.Have you ever had any medical conditions related to your family (genetic) illness e.g sickle cell anaemia, thalassemia, haemophilia, cleft lip/palate</li> <li>25.Have you ever had any medical conditions related to Allergies e.g to medicines, penicillin, foods, substances, hayfever, latex</li> <li>25.Have you ever had any medical conditions related to Mental Health problems, e.g anxiety, depression, anorexia, bullimia, psychosis</li> <li>27.Have you ween had any medical condition</li></ul>		
Blood pressure, high cholesterol, deep vein thrombosis, pulmonary embolism, aneurysm         14.Have you ever had any medical conditions related to your blood e.g. anaemia, prolonged bleeding following injury, surgery, or tooth extraction, immunity problem.       YES/NO         15. Have you ever had any medical conditions related to your breathing e.g asthma or VES/NO       YES/NO         16.Have you ever had any medical conditions related to your breathing e.g asthma or vES/NO       YES/NO         or blackouts (e.g.epilepsy), stroke, dementia, Parkinson's Disease, Multiple sclerosis       YES/NO         17.Have you ever had any medical conditions related to your stomach and digestion e.g reflux, Indigestion, ulcers, ulcerative colitis, Crohn's Disease.       YES/NO         18.Have you ever had any medical conditions related to your genital or urinary e.g       YES/NO         19.Have you ever had any medical conditions related to your genital or urinary e.g       YES/NO         Kidney disease, prostate problems, gynaecological problems       YES/NO         20.Have you ever had any medical conditions related to your skin e.g. e.g Osteoporosis, arthritis, replacement joints, osteogenesis imperfecta, receive bisphosphonate therapy       YES/NO         21.Have you ever had any medical conditions related to your skin e.g. e.g. exema, provida problems, Addison's disease       YES/NO         21.Have you ever had any medical conditions related to your skin e.g. e.g. exema, provida problems, and any medical conditions related to your skin e.g. e.g. exema, provida problems, anotinst, osteogenesis imperfecta, receive bisph		YES/NO
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