QANTAS SUPER

Personal Statement (request for insurance)

MLC Limited is the appointed Insurer for the Qantas Superannuation Plan.

Use this form to apply for or increase your insurance cover. You will also need to complete the Application for Voluntary Cover form or Application to Increase Basic Cover form, depending on your circumstances.

You can also use this form to apply to remove any exclusions or limitations on your existing cover in Qantas Super.

Your Duty of Disclosure

Insurance Contracts Act 1984

Before you enter into a contract of life insurance with an insurer, you have a duty under the Insurance Contracts Act 1984, to disclose to the insurer every matter that you know, or could reasonably be expected to know which is relevant to the insurer's decision whether to accept the risk of the insurance and, if so, on what terms.

You have the same duty to disclose those matters to the insurer before such a contract of life insurance is extended, varied or reinstated.

Your duty, however, does not require a disclosure of a matter:

- That diminishes the risk to be undertaken by the insurer; or
- That is of common knowledge; or
- That your insurer knows or, in the ordinary course of business, ought to know; or
- For which your duty of compliance is waived by the insurer.

Where the Trustee of Qantas Super obtains life insurance from the Insurer on you, the Trustee requires you to make full disclosure to it on the same basis.

It also applies if you seek to extend, vary or reinstate the contract.

Non-disclosure

If you fail to comply with your Duty of Disclosure and the insurer would not have entered into the contract on any terms if the failure had not occurred, the insurer may avoid the contract within three years of entering into it. If your non-disclosure is fraudulent, the insurer may avoid the contract at any time.

An insurer who is entitled to avoid a contract of life insurance may, within three years of entering into it, elect not to avoid it but reduce the sum that you have been insured for in accordance with a formula that takes into account the premium that would have been payable if you had disclosed all relevant matters to the insurer.

Your Duty of Disclosure continues until the contract of life insurance has been accepted by the insurer and confirmation in writing is issued. It also applies if you seek to extend, vary or reinstate the contract.

1. Insurance details

Policy number (office use only)

Policy name

Qantas Superannuation Plan

Member number

Division

1. Insurance details continued

I want to:

- ☐ Increase my Basic Cover. My completed Application to increase Basic Cover form is attached.
- ☐ Apply for or increase my Voluntary Cover. My completed Application to Increase Voluntary Cover form is attached.
- ☐ Apply to have any exclusions/ limitations removed from my existing cover.
- ☐ Apply for Basic Cover above the Plan's Automatic Acceptance Limits.

Note: If you are unsure of your current level of cover or require assistance to complete this section please contact the Qantas Super Helpline on **1300 362 967** (from overseas **+61 3 8687 1866**).

Office Use Only

Basic Cover (Only available to Gateway Members)
☐ Death only ☐ Death and TPD ☐ Income Protection

Voluntary Cover
☐ Death only ☐ Death and TPD

Existing Cover
☐ Remove PEC / Limited Cover

	Current cover	**New cover**	**Total cover**
Multiple of salary			
Fixed cover (mulitples of $10,000)	$	$	$

2. Personal details

Person whose life is to be insured

Title
Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other ☐

First name

Middle name

Surname

Date of birth (DD/MM/YYYY)

Gender
☐ Male ☐ Female

Maiden name (if applicable)

Contact address for notices

Unit number

Street number

Street name

Suburb

State

Postcode

Country

Mobile phone number

Home telephone

Business telephone

Facsimile

Email

3. Employment details

1 Name of current employer

2 What is your current occupation?

a What professional or trade qualifications do you have?

b On what basis are you employed?

☐ Full-time ☐ Part-time ☐ Casual

☐ Contractor ☐ Fixed-term employment

Note: Fixed-term employment means you are employed for a fixed-term period of employment determined at the commencement of your employment and where you are in receipt of leave, sick leave, superannuation and other benefits normally associated with full-time employment.

c Date you started with your **current** employer (DD/MM/YYYY)

3 What is your Annual Salary?

$

4. Additional details

1 Have you ever made a claim or received benefits in regard to any illness, injury or condition?

Yes ☐ Please provide details in table below

Benefit type	Benefit amount	Reason for claim	Time off work	Date finalised
	$			
	$			
	$			
	$			
	$			
	$			

No ☐ Please go to **Question 2**

2 Are you covered by, or are you applying for, any other life, disability, critical illness, income protection, salary continuance or business expenses insurance with any company, including the Insurer (other than this application), including benefits under superannuation or insurance benefits provided by your employer?

Yes ☐ Please provide details below

Company	Benefit type	Date started	Benefit amount	Waiting / benefit periods	Policy number	To be replaced
			$			Yes ☐ No ☐
			$			Yes ☐ No ☐
			$			Yes ☐ No ☐
			$			Yes ☐ No ☐
			$			Yes ☐ No ☐
			$			Yes ☐ No ☐

No ☐ Please go to **Section 5**

5. Sports and pastimes

1 Do you now or do you intend to take part in any of the following activities?

Yes ☐ Please tick all that apply and provide details below.

- ☐ Diving
- ☐ Motor car, motor cycle or motor boat racing
- ☐ Flying as a pilot or crew in an aircraft

If you ticked any of these boxes, please complete the **Pastimes Questionnaire** located on pages 13-14.

- ☐ Football (all codes)
- ☐ Hang-gliding, paragliding, skydiving, pursuits involving heights
- ☐ Other hazardous pursuits (eg body contact sports, mountain climbing, abseiling, downhill mountain biking)

If you ticked any of these boxes, please provide full details of each below.

Activity	Activity
Location	Location
☐ Recreational ☐ Professional ☐ Competitive	☐ Recreational ☐ Professional ☐ Competitive
Events/hours per year:	Events/hours per year:
Other details	Other details

No ☐ Please go to **Section 6**

6. Health and medical history

1 What is the name and address of your usual doctor or medical centre? **(If no usual doctor, then the last doctor you last visited).** If you have known this doctor for less than 12 months, please also advise your previous doctor's details at **Question 18 on page 12**. **This question must be completed.**

Name of doctor or medical centre

Unit number | Street number | Street name

Suburb | State | Postcode | Country

Business telephone

How long have you known this doctor? years months

Date of your last consultation or check-up (DD/MM/YYYY)

Please go to **Question 2**

2 Have you ever had, or been told you had, or ever sought advice or treatment from a doctor, counsellor or other health professional for any of the following:

Yes ☐ Please tick all that apply and provide details below.

Condition	Questionnaire
☐ Stress, anxiety, depression, post traumatic stress disorder (PTSD) or any other mental health disorder	Please complete the **Mental Health** Questionnaire located on **page 15**
☐ High blood pressure	Please complete the **High Blood Pressure** Questionnaire located on **page 16**
☐ High cholesterol	Please complete the **High Cholesterol** Questionnaire located on **page 17**
☐ Asthma	Please complete the **Asthma** Questionnaire located on **page 18**
☐ Skin cancer, tumour, cyst, lesion or mole	Please complete the **Skin Lesion** Questionnaire located on **page 19**
☐ Back or neck strain/sprain or pain, sciatica, whiplash, spondylitis, fracture or any back, neck or spinal problem	Please complete the **Back/Neck** Questionnaire located on **page 20**
☐ Any bone/joint fractures, muscle, ligament or tendon injuries, tenosynovitis, gout, arthritis or osteoporosis	Please complete the **Joint/Musculoskeletal** Questionnaire located on **page 22**

No ☐ Please go to **Question 3**

3 Are you carrying the Human Immunodeficiency Virus (HIV) which causes AIDS, antibodies to that virus, or are you suffering from AIDS or any AIDS related condition?

Yes ☐

No ☐

6. Health and medical history continued

4 In the last three years, are you aware of any HIV risk situation to which you or any of your sexual partners may have been exposed?

Note: HIV risk situations include but are not limited to:

- sex with someone you know or suspect to be HIV positive
- sex with an intravenous drug user
- sex without a condom with a sex worker
- anal intercourse without a condom (except in a relationship between you and one other person only and neither of you have had sex with anyone else for at least three years).

Yes ☐ ▶ A private and confidential questionnaire will be mailed to you upon submission of this application.

No ☐

5 Do you drink alcohol?

Yes ☐ ▶ Number of standard drinks

per day **OR** per week

Note: 1 standard drink = 1 glass of beer/wine/nip of spirit

No ☐ ▶ Please go to **Question 6**

6 Have you smoked tobacco or any other substance or used any nicotine-containing product in the last 12 months?

Yes ☐ ▶ What type? eg cigarettes, gum, patch

Daily quantity

No ☐ ▶ Please go to **Question 7**

7 What is your height/weight?

cm kg

6. Health and medical history continued

8 Do you have or have you ever had any of the following? Please tick (✓) the appropriate box.

	Condition	Yes	No
a	Heart complaint		
b	Epilepsy or any neurological disorder		
c	Stroke or vascular disorder		
d	Lung complaint		
e	Diabetes, bowel, kidney or bladder disorder		
f	Alcohol or drug dependence		
g	Professional advice to reduce alcohol consumption		
h	Migraine, persistent headache or chronic fatigue		
i	Disorder of the reproductive system (eg prostate, ovary), or sexually transmitted disease		
j	Cancer or leukaemia		
k	Haemophilia or blood disorder		
l	Thyroid disorder		
m	Liver disorder, hepatitis or test indicating past or present hepatitis infection		
n	Any allergies, skin disorder, or disorder of the eyes, ears, nose or throat		
o	Any other operation, disability, illness or injury, medical investigation or test (eg genetic test, mammogram, ultrasound, ECG) not already mentioned		

If you answered 'Yes' to any item in this question please provide details below.

Question	Illness, injury, condition or test	Test result	When did it start?	When did it end?	Type of treatment and when treatment end	How long off work?	Have you completely recovered?	Name and address of institution and attending person

6. Health and medical history continued

9 Other than already stated, have you in the last 5 years:

a Taken any prescribed medication on a regular or ongoing basis? (other than for colds or flu)

Yes ☐ Please provide details in the table below.

No ☐

b Used (by mouth, inhalation or injection) any drug not prescribed by a doctor, other than medicines purchased at a chemist?

Yes ☐ Please provide details in the table below.

No ☐

Provide details below. If there is not enough space here, please list at question 18 on page 12.

Question	Illness, injury, condition or test	Test result	When did it start?	When did it end?	Type of treatment and when treatment end	How long off work?	Have you completely recovered?	Name and address of institution and attending person

10 Do you now have any other disability, illness, injury or symptoms not already mentioned?

Yes ☐ Please provide details below

No ☐ Please go to **Question 11**

11 Do you contemplate seeking any advice, test, investigation or treatment?

Yes ☐ Please provide details below

No ☐ Please go to **Question 12**

Provide details below. If there is not enough space here, please list at question 18 on page 12.

Question	Illness, injury, condition or test	Test result	When did it start?	When did it end?	Type of treatment and when treatment end	How long off work?	Have you completely recovered?	Name and address of institution and attending person

6. Health and medical history continued

12 Have any of your parents, brothers or sisters (living or dead) suffered from any of the following?

- Cancer (specify type and site)
- Heart disease
- Stroke
- Diabetes
- Kidney disease
- Rheumatoid arthritis
- Huntington's disease
- Motor neurone disease
- Muscular dystrophy
- Familial polyposis
- Any other hereditary disorder
- Multiple sclerosis

Yes ☐ Please provide details below.

Relationship	Medical condition	Cancer type and site	Age condition began	Age at death (if applicable)

No ☐

Females only

13 Have you had any complications of pregnancy or childbirth?

Yes ☐ Please provide details below

No ☐ Please go to **Question 14**

14 Are you currently pregnant?

Yes ☐ Due date (DD/MM/YYYY)

No ☐ Please go to **Question 15**

15 Have you ever had an abnormal pap smear?

Yes ☐ When (DD/MM/YYYY) Treatment

Date and result of most recent pap smear

No ☐ Please go to **Question 16**

6. Health and medical history continued

Further information

You can use this space to provide further information. Please note the page and question number the additional information refers to.

Page no.	Question no.	Further information

7. Your agreement and declaration

Read this section carefully before signing.

I understand and agree that:

(a) I have read the Duty of Disclosure set out on **page 1**.
I understand that, until the Insurer accepts this application and I have a duty to disclose every matter which I know, or could reasonably be expected to know, is relevant to the Insurer's acceptance of this application and that if I fail to comply with my duty of disclosure the Insurer may (as permitted by law) decline to pay or reduce the benefits under it;

(b) The answers to the questions in this application and any other relevant personal statement(s) and questionnaires are true and complete, and the answers given form the basis of the contract;

(c) If any answers to the application questions are not in my own handwriting, I certify that I have checked them and they are correct;

(d) I will provide the Insurer or the Trustee or any appointed administrator with any information which relates to my membership of Qantas Super which they may request;

(e) This insurance application is not effective until the Insurer accepts this application and issues a confirmation, except for Interim Accident Insurance that will apply subject to specific terms and conditions;

(f) I was actively at work performing the normal duties of my occupation when I applied for this insurance;

(g) All statements and declarations given by me on this form are true and correct; and

(h) The information contained in this application may be released to the Qantas Super Trustee which has arranged this insurance, or to an administrator appointed by the Trustee for the purposes of administering this insurance.

I authorise the Insurer to:

(a) Collect further medical information from any doctor, medical centre, hospital or any other health service provider identified by me in this application for the purpose of assessing my application for insurance;

(b) Provide my personal, financial and medical information (whether provided in this application or otherwise subsequently collected by the Insurer with my consent) to any medical professional, medical facility, reinsurer, assessor, adviser or any other confidential service provider, now or at any time in the future, for the purpose of issuing or administering this insurance, and assessing any claim made in respect of this insurance;

(c) Provide a copy of any test results (except the HIV Antibodies Blood Test) I have undergone in connection with this application to my usual doctor or medical centre as nominated at **Section 6, Health and Medical History**;

(d) Provide a copy of the HIV Antibodies test to my usual doctor or medical centre as nominated at **Section 6, Health and Medical History** unless I have nominated an alternative doctor to receive the results, in which case I authorise the results to be provided to the alternative doctor specified.

I also authorise the Insurer and any third party referred to in paragraphs (a), (b), (c) and (d) of this authority, to transfer any such information outside the State, Territory or jurisdiction in which the information was collected in order to give effect to this authority.

Privacy

I acknowledge that I have access to the Insurer's privacy policy and agree that the Insurer may collect, use, disclose and handle my personal information in a manner set out in the Insurer's privacy policy available on **mlc.com.au**

I acknowledge that where my Employer (or former Employer) or the Qantas Super Trustee has appointed an adviser, intermediary or administrator to arrange and/or administer the insurance policy on their behalf, my personal information, including my pastime activities, occupation and financial status will be provided to the Insurer for the purpose of expediting the assessment of this application for insurance.

Consent

I consent that where my application is declined, loaded and/or an exclusion is applied, the Insurer may disclose any personal medical information or finding that resulted in my application being declined, loaded and/or having an exclusion applied, to the adviser, intermediary or administrator providing services in relation to this insurance.

I understand I can withdraw this consent at any time by contacting the Insurer on **02 8908 6111** or email **group_insurance @mlc.com.au**

Where, in the Insurer's opinion, your medical information or our findings are of a personal or sensitive nature, the Insurer reserves the right to withhold disclosure of this information to the appointed adviser, intermediary or administrator.

Have you completed or were you requested to complete any Questionnaires in this Application Form?

Yes ☐ ▶ Please complete the relevant Questionnaires and return the completed Application Form and Questionnaires to us.

No ☐ ▶ Please make sure you have completed and signed the Application Form from **page 1 to 13.**

Signature of Applicant

Full name (please print)

____

X ______________________ Date (DD/MM/YY) __ __ / __ __ / __ __

Please also complete the Medical Authority on page 12.

(DO NOT DETACH)

Medical authority

Please sign and date both Medical Authorities

MLC Limited
ABN 90 000 000 402
AFSL 230694

Authority to obtain a report from a medical practitioner or hospital – A representative of the Insurer will complete the appropriate doctor's details in the space below.

I request and authorise you to supply the Insurer and/or its appointed medical service providers, with full particulars of my medical history including details of any clinical notes that have been made. I acknowledge that this may require you to transfer such information to another State, Territory or jurisdiction.
A photocopy of this authorisation shall be as valid as the original.

If married, what is your maiden name?

Signature of Applicant

✗ Date (DD/MM/YY)

(DO NOT DETACH)

Medical authority

Please sign and date both Medical Authorities

MLC Limited
ABN 90 000 000 402
AFSL 230694

Authority to obtain a report from a medical practitioner or hospital – A representative of the Insurer will complete the appropriate doctor's details in the space below.

I request and authorise you to supply the Insurer and/or its appointed medical service providers, with full particulars of my medical history including details of any clinical notes that have been made. I acknowledge that this may require you to transfer such information to another State, Territory or jurisdiction.
A photocopy of this authorisation shall be as valid as the original.

If married, what is your maiden name?

Signature of Applicant

✗ Date (DD/MM/YY)

8. Send us your form

Please mail your completed, signed and dated form to us at:

MLC Group Insurance
PO Box 200
North Sydney NSW 2059

Email: group_insurance@mlc.com.au

If you have any questions, please call us on **02 8908 6111** on Monday to Friday between 8.00 am and 6.00 pm (AEST/AEDT).

Pathology request for insurance

This must be completed when a blood test is required.

Title | Surname (Family name) (please print) | Given name | Sex | Date of birth (DD/MM/YYYY)

Policy name

Family doctor or hospital – name and address

Postcode

Policy/Account number

Report and account to	Collection date and time	Tests require
MLC Group Insurance PO Box 200 North Sydney NSW 2059 Phone: 02 8908 6111	Date of appointment Time of appointment am/pm	☐ Multiple Biochemical Analysis 20 ☐ HIV Antibodies ☐ Hepatitis B and C serology ☐ Other (specify)

Members consent (not to be signed prior to attendance)

I give my consent to the tests nominated above including any reflex testing for Hepatitis B and C to be performed. Where one is for the presence of antibodies to the AIDS virus (HIV). I acknowledge that I have read the material provided by the Insurer (see over) on the implication of the test and understand its significance. I authorise the sending of a copy of the test results to the Insurer and to my family doctor as shown above.

☐ No ☐ Yes

Member's signature

✗ Date (DD/MM/YY)

Information about the HIV antibody blood test

To fully assess this application for insurance, we may request you undergo an HIV antibody blood test. This test could be arranged through your own doctor, by consulting a doctor arranged by us or directly with the pathology laboratory. This test is completely voluntary. However, if you refuse the test, it could affect our willingness to accept this application.

Acquired Immune Deficiency Syndrome (AIDS) is a viral disease caused by the Human Immunodeficiency Virus (HIV) which destroys some of the white blood cells in our bodies. These white blood cells help protect our bodies against infection and cancers. Some people infected with HIV therefore suffer infections or cancers and, in some cases, direct damage to the brain by the virus. The most recent evidence suggests that the virus will persist in the body indefinitely. As yet, there is no cure for AIDS.

Following infection, there may be mild flu-like symptoms or no symptoms at all. The body subsequently manufactures antibodies to the virus, usually within 8 to 12 weeks, but occasionally longer. These antibodies can be detected by a blood test and this is the test proposed. The infected individual may remain free of symptoms for many years, but during this time may pass on the infection to others. The first symptoms may include weight loss, fever, swollen glands, diarrhoea, coughs, cancer or nervous system diseases.

A positive result

If the result of the HIV antibody test is positive, this means:

1. You have been infected by HIV,
2. You can pass this infection:
   (a) to any unprotected sexual partner,
   (b) to anyone receiving your blood, donated organs or semen,
   (c) if you are an intravenous drug user, to anyone sharing syringes or needles with you,
   (d) if you are a woman, to a baby during pregnancy, and perhaps at birth or by breast feeding.

   There is no evidence that the virus can be spread by other types of contact, such as touching, sharing eating utensils, coughing, sneezing or from mosquito bites.
3. Full AIDS is notifiable throughout Australia. In some States and Territories, HIV infection and other early stages of the disease are also notifiable to the health authority. In most cases, notification is by name and address, though in some States, it is by code.
4. Knowing that you are HIV antibody positive has legal consequences in all States and Territories, although they vary. It may exclude you from some jobs and from access to some services. It can be an offense to knowingly transmit the virus or put someone at risk of infection through sexual activity. There are quarantine provisions which may be used if the authorities consider it appropriate.
5. In many cases, the full effects of AIDS will develop at some stage and the long-term outlook is still uncertain. As a result, life and disability insurance is unlikely to be available to anyone infected with HIV.

If the result of the test is positive, it is important that you receive appropriate counselling from a doctor. You are asked to nominate your family doctor to give you this counselling in the consent declaration contained in the Application form attached to this brochure. You may wish to nominate an alternative doctor. We will pass a positive result on to that doctor for onward communication to you.

A negative result

If the result of the HIV antibody test is negative, this means, either that you have not been infected or that you have been infected recently but your body has not yet had time to manufacture antibodies. However, you should be alert to the risk of becoming infected and refrain from activities which make that possible – particularly unsafe sexual practices and sharing of syringes or needles.

The choice is yours

You may choose not to have the test for a variety of reasons, eg you may feel you would not be able to cope with the knowledge of a positive result and the medical implications which follow, or you may be concerned about the social implications (discrimination, stigma, etc). You may feel that you would like more information first, in which case you are advised to seek advice from your own doctor. If you do not have one, or would prefer advice from elsewhere, you should see a specialist counsellor on the subject. Government and community organisations provide AIDS counselling services. If you choose to have the test arranged by us, we are concerned to protect your privacy. The result will be sent under confidential cover to the Insurer's Chief Medical Officer. A positive result will not be transferred to the Insurer's general records on your application for insurance.

Pastimes questionnaire

Underwater diving

1 Do you hold a diving qualification?

Yes ☐ Type of qualification and time held

No ☐ Please go to **Question 2**

2 Are you a Professional Diver?

Amateur ☐ Please go to **Question 3**

Professional ☐ Please provide details below

3 What type of diving do you do?

☐ Scuba

☐ Hookah

☐ Snorkel

☐ Other – please provide details

4 Please advise the following:

Average number of dives per year

Average depth of dives

Maximum depth and number of times attained

Average duration of dives

Maximum duration of dives

5 Do you dive in caves, potholes or wrecks?

Yes ☐ Please provide details

No ☐ Please go to **Question 6**

7 Do you ever dive alone?

Yes ☐ Please provide details

No ☐ Please go to **Question 8**

8 Have you ever had an accident whilst diving or suffered an injury?

Yes ☐ Please provide details

No ☐

Motor racing

1 What types, classes, and engine capacity of vehicles do you race or intend to race?

2 What types of racing do you participate in? (eg stock car, circuit racing, road racing, etc)

3 Do you compete as:

☐ Amateur ☐ Professional ☐ Competitive

4 How many times do you race per year?

5 Do you intend to change the scope of your current participation?

Yes ☐ Please provide details

No ☐ Please go to **Question 6**

Aviation

1 Do you hold an aviation licence?

Yes ☐ Type of licence and period of time held

No ☐ Please go to **Question 2**

2 Do you intend to change the scope of your licence, or engage in any other form of aviation other than as shown below?

Yes ☐ Please provide details

No ☐ Please go to **Question 3**

3 Please complete number of flying hours in the following table:

	Flying hours	
	Last year	**Future average**
Commercial Airline		
Charter		
Private		
Aero Club/Flying School		
Agriculture		
Ultralight/Micro		
Helicopter		

Mental health questionnaire

1 Please indicate the conditions you have had or received treatment or counselling for.

- ☐ Stress, sleeplessness, chronic tiredness
- ☐ Anxiety including generalised anxiety, reactive or grief anxiety, panic or phobic disorder
- ☐ Eating disorder including anorexia nervosa, bulimia
- ☐ Depression including major depression, dysthymia
- ☐ Manic depressive illness, bipolar disorder
- ☐ Alcohol or other substance abuse or addiction
- ☐ Post traumatic stress disorder (PTSD)
- ☐ Attention Deficit and/or Hyperactivity Disorder (ADD/ADHD)
- ☐ Schizophrenia or any other psychotic disorder
- ☐ Other – please provide details in the box below

2 Please describe your symptoms, the date they started, how long they lasted and time off work.

Symptoms	**Date from – Date to** (DD/MM/YYYY)	**Time off work**

3 Please describe how this condition has affected you, including any limitations to your ability to work and in your activities of daily living.

4 Has any reason for your condition been identified?

Yes ☐ Please provide details

No ☐ Please go to **Question 5**

5 When was your condition first diagnosed? (DD/MM/YYYY)

6 Have you ever received any counselling or treatment for this condition? (eg medication, cognitive behaviour therapy).

Type of treatment	**Date commenced** (DD/MM/YYYY)	**Date ceased** (DD/MM/YYYY)

7 Do you continue to experience symptoms?

Yes ☐ Please describe your symptoms

No ☐ When did you **last** experience symptoms? (DD/MM/YYYY)

8 Have you had any recurrence of this condition or suffered from or had symptoms of a similar condition?

Yes ☐ Please provide details

No ☐ Please go to **Question 9**

9 Please provide the name and address of health professionals, including counsellors consulted and the date first and last consulted.

Name	**Address**	**Date** (DD/MM/YYYY)

High blood pressure questionnaire

1 When were you first told you had high blood pressure? (DD/MM/YYYY)

2 What was your last blood pressure reading and when was it taken?

Date (DD/MM/YYYY) Reading

3 Is this reading consistent with other checks?

Yes Please go to **Question 4** No What is your typical reading?

4 How often are you required to attend your doctor for review/check-up?

Monthly Quarterly Twice yearly Annually

5 Have you undergone or been referred for any other investigations? (eg ECG (resting or exercise), echocardiogram, 24 hour Holter monitoring, urinalysis).

Yes Please provide dates, tests done and results.

Date (DD/MM/YYYY) Test Results

No Please go to **Question 6**

6 Are you currently taking medication for your blood pressure?

Yes Please provide medication and dosage No Please go to **Question 8**

7 Has your treatment (type or dosage) changed within the last 12 months?

Yes Please provide details and then go to **Question 9**

When was it changed? (DD/MM/YYYY) What was changed? Why has it changed?

No Please go to **Question 9**

8 Have you ever been prescribed medication for your blood pressure?

Yes When and why did you cease taking it? No How has the condition been managed?

9 Please provide the name and address of doctor, hospital or health professional consulted for your blood pressure and date last attended.

Name	**Address**	**Date** (DD/MM/YYYY)

High cholesterol questionnaire

1 When were you first told you had raised cholesterol? (DD/MM/YYYY)

2 What was your last cholesterol reading and when was it taken?

Date (DD/MM/YYYY)

Reading

3 Is this reading consistent with other checks?

Yes Please go to **Question 4**

No What is your typical reading?

4 How often are you required to attend your doctor for review/check-up?

Monthly Quarterly Twice yearly Annually

5 Have you undergone or been referred for any other investigations? (eg ECG (resting or exercise), echocardiogram, 24 hour Holter monitoring, urinalysis).

Yes Please provide dates, tests done and results.

Date (DD/MM/YYYY) Test Results

No Please go to **Question 6**

6 Are you currently taking medication for your cholesterol?

Yes Please provide medication and dosage

No Please go to **Question 8**

7 Has your treatment (type or dosage) changed within the last 12 months?

Yes Please provide details and then go to **Question 9**

When was it changed? (DD/MM/YYYY) What was changed? Why has it changed?

No Please go to **Question 9**

8 Have you ever been prescribed medication for your cholesterol?

Yes When and why did you cease taking it?

No How has the condition been managed?

9 Please provide the name and address of doctor, hospital or health professional consulted for your cholesterol and date last attended.

Name	**Address**	**Date** (DD/MM/YYYY)

Asthma questionnaire

1 When did you experience your first episode/symptoms of asthma? (DD/MM/YYYY)

2 Have you suffered from any symptoms of asthma in the last 5 years?

Yes ☐ When was the date of your most recent episode/symptoms of Asthma? (DD/MM/YYYY)

No ☐ Please go to **Question 8**

3 How many episodes of asthma do you have per year?

4 Are you taking medication or have you used any medication (including steroids) within the last 12 months?

Yes ☐ Please provide the name of medications and date ceased (if applicable)

No ☐ Please go to **Question 5**

5 Have you ever been hospitalised for this condition or needed to attend a hospital or doctor for urgent medical treatment?

Yes ☐ Please provide the name of hospitals, doctors and dates

Name of hospital	**Address of hospital/doctors' surgery**	**Date** (DD/MM/YYYY)

No ☐ Please go to **Question 6**

6 Have you lost any days from work as a result of asthma in the last 12 months?

Yes ☐ Please advise the number of days

No ☐ Please go to **Question 7**

7 Is your asthma related to or aggravated by your occupation?

Yes ☐ Please provide details

No ☐ Please go to **Question 8**

8 Please provide the name and address of any doctors, hospitals or other health professionals consulted for your asthma and the date last consulted.

Name	**Address**	**Date** (DD/MM/YYYY)

Cyst/mole/skin lesion questionnaire

1 Site of lesion(s)

2 Type of lesion(s)

- ☐ Melanoma
- ☐ Squamous cell carcinoma (SCC)
- ☐ Basal cell carcinoma (BCC)
- ☐ Solar keratosis
- ☐ Lipoma
- ☐ Cyst
- ☐ Mole/Naevus
- ☐ Other – please specify

3 Number of lesion(s)

4 Date(s) of diagnosis (DD/MM/YYYY)

5 Were the lesion(s) removed?

Yes ☐ Please go to **Question 7** No ☐ Please provide details below

6 Have you been advised to attend for any further treatment or follow-up?

Yes ☐ Please provide details below, then go to **Question 10** No ☐ Please go to **Question 11**

7 Date lesion(s) removed (DD/MM/YYYY)

8 How were the lesion(s) removed?

- ☐ Diathermy (burnt off)
- ☐ Cryotherapy (frozen off)
- ☐ Cut off (surgically removed)
- ☐ Other – please specify

9 Since the original removal have you been required to undergo re-excicion or has the lesion(s) recurred or regrown?

Yes ☐ Please go to **Question 10** No ☐ Please provide details below

10 Were the lesion(s) reported to be:

- ☐ Malignant/Cancerous
- ☐ Benign/Non-Cancerous
- ☐ Unknown

Note: Please forward copies of any histology reports you have.

11 Please provide the name and address of any doctors, hospitals or other health professionals consulted for your skin lesions and the date last consulted.

Name	**Address**	**Date** (DD/MM/YYYY)

Back/neck questionnaire

1 When did you first experience back/neck symptoms? (DD/MM/YYYY)

2 What is/was the cause of your back/neck disorder?

3 What is/was the cause of your back/neck disorder?

☐ Neck (Cervical) ☐ Upper/Middle back (Thoracic) ☐ Lower Back (Lumbar)

4 What is/was the exact nature of the back/neck disorder including symptoms?

5 What was the date of your last symptoms? (DD/MM/YYYY)

6 Have you had an x-ray, scan or other test?

Yes ☐ Please provide details

No ☐ Please go to **Question 7**

7 What treatment have you had?

☐ Medication ☐ Chiropractor ☐ Physiotherapy
☐ Surgery ☐ Other – please specify

8 Have you made a complete recovery?

Yes ☐ How long have you been free of all symptoms?

Please go to **Question 13**

No ☐ Please go to **Question 9**

9 What are your current symptoms?

10 How often do you experience symptoms? (eg Daily/Weekly/Monthly/Yearly).

11 What is duration of your symptoms?

12 Does this condition cause any restriction in your daily activities?

Yes ☐ Please provide details

No ☐ Please go to **Question 12**

13 Have you taken time off work?

Yes ☐ Please advise when and how long you were off work

No ☐ Please go to **Question 14**

14 Please provide the name and address of any doctors, hospitals or other health professionals consulted for your skin lesions and the date last consulted.

Name	**Address**	**Date** (DD/MM/YYYY)

Joint/musculoskeletal questionnaire

1 Which joint(s) or area(s) of the body is/are affected?

☐ Left ☐ Right

2 What is/was the exact nature of the disorder including symptoms?

3 What is/was the cause of the condition?

4 When did you **first** experience symptoms? (DD/MM/YYYY)

5 What was the date of your **last** symptoms? (DD/MM/YYYY)

6 What treatment have you had?

☐ Medication ☐ Surgery ☐ Physiotherapy ☐ Other – please specify

Date ceased (DD/MM/YYYY)

7 Have you made a complete recovery?

Yes ☐ How long have you been free of all symptoms?

Please go to **Question 11**

No ☐ Please go to **Question 8**

8 What are your current symptoms?

9 How often do you experience symptoms?

10 Does this condition cause any restriction in your daily activities?

Yes ☐ Please provide details

No ☐ Please go to **Question 12**

11 Have you taken time off work?

Yes ☐ Please advise when and how long you were off work

No ☐ Please go to **Question 13**

12 Please provide the name and address of any doctors, hospitals or other health professionals consulted for your skin lesions and the date last consulted.

Name	**Address**	**Date** (DD/MM/YYYY)

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