WYGGESTONS

(Founded 1513)

Registered Charity Number 216873

Applicant's Name: ……………………………………………………………………………………………..…………..……

Address…………………………………………………………………………………………………

………………………………………………………………………………………………………….

Date of Birth………………………………………………………..……

Medical Information Request Form

(For prospective residents of Wyggestons)

**Questionnaire**

1. Have you ever suffered or suffering from any of the following – if yes give details and dates, or state no**.** Do not leave any blanks**:**
2. Diabetes Mellitus……………………………………………………………………………………………..…………
3. High blood pressure……………………………………………………………………………………………………
4. High Cholesterol…………………………………………………………………………………………………………
5. Heart Disease……………………………………………………………………………………………………………..
6. Stroke, Fainting Attack…………………………………………………………………….………………………...
7. Asthma, Respiratory Infections, Tuberculosis…………………………………………………………….
8. Mental Health Issues……………………………………………………………………………………..…………..
9. Depression………………………………………………………………………………………………………………….
10. Dementia……………………………………………………………………………………………………………………
11. Any disease of bones/joints………………………………………………………………………………………..
12. Mobility problems………………………………………………………………………………………………………
13. Back problems…………………………………………………………………………………………………………….
14. Arthritis………………………………………………………………………………………………………………………
15. Cancers……………………………………………………………………………………………………………………….

Pto

1. Diseases of Stomach, Intestine, Liver, Gall Bladder/Pancreas, Kidney, Urinary

Bladder, Urinary Tract Disease…………………………………………………………………………………..

…………………………………………………………………………………………………………………………………..

1. Hearing Loss……………………………………………………………………………………………………………….
2. Ear/Nose/throat Problems…….……………………………………………………………………………………

……………………………………………………………………………………………………………………………………

1. Eyesight problems………………………………………………………………………………………………………
2. Cataract………………………………………………………………………………………………………………..……
3. Glaucoma……………………………………………………………………………………………………………………
4. Macular Degeneration…………………………………………………………………………………………..……
5. Any other problem(s)………………………………………………………………………………………………….

……………………………………………………………………………………………………………………………………

……………………………………………………………………………………………………………………………………

……………………………………………………………………………………………………………………………………

1. Details of drugs and medicines prescribed (Please List) Plus dosages:

1.…………………………………………………………4……………………………………………………………………

2. …………………………………………………………5……………………………………..……………………………

3. …………………………………………………………6.………………………………………………………………….

I……………………………………………………………..confirm that the above information is correct to the best of my knowledge.

Signed…………………………………………………..

Date……………………………………………………..