

# Group Risk

## Personal Statement

15 November 2010

### OnePath Life Limited (OnePath Life)

ABN 33 009 657 176 AFSL 238341

GPO Box 4129, Sydney NSW 2001

### Group Risk Insurance Administration

**Phone** 1800 648 921

**Fax** 02 9234 8072

**Email** [group.risk@onepath.com.au](mailto:group.risk@onepath.com.au)

**Website** [onepath.com.au](http://onepath.com.au)

### Important notice

OnePath Life is the insurer in respect of a group insurance arrangement. It is important that you have read and understood the current Product Disclosure Statement for the cover for which you are applying.

You are requested to complete this form if one of the following applies to you:

- you are proposing to become an insured member under the policy and your benefits are subject to assessment by OnePath Life
- you are an existing insured member and your benefit (or part thereof) is subject to assessment by OnePath Life.

OnePath Life requires this Personal Statement and other health information to assist us in making a decision on your proposed insurance cover. This Personal Statement is confidential. Please refer to the Privacy Statement in the Product Disclosure Statement.

You may wish to seal it in an envelope and send it to:

#### OnePath Life

GPO Box 4129

Sydney NSW 2001

### Your duty of disclosure

You have a duty under the *Insurance Contracts Act 1984* (Cth) to disclose to the insurer every matter that you know or could reasonably be expected to know, is relevant to the insurer's decision whether to accept the risk of insurance and, if so, on what terms.

Your duty of disclosure applies even after your application is completed and until the insurer has assessed and accepted your application for insurance cover, or an increase in cover.

You have the same duty to disclose those matters to the insurer before you change your insurance cover or apply for new cover. Your duty, however, does not require disclosure of a matter that:

- diminishes the risk to be undertaken by the insurer
- is of common knowledge
- the insurer knows, or in the ordinary course of business, ought to know or
- the insurer has waived.

### 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 to 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.

### Postal address

OnePath Life

GPO Box 4129

Sydney NSW 2001

### Street Address

347 Kent Street

Sydney NSW 2000

Tel 1800 648 921

Fax 02 9234 8072

### Website

[onepath.com.au](http://onepath.com.au)



3. Have you ever had an application for insurance on your life declined, deferred, accepted with a higher than normal premium or issued with restrictions or exclusions? .....  Yes  No

If **yes**, please provide name of company, alteration, date and reason (if known).


4. Have you ever made a claim for or received sickness, accident or disability benefits, Veterans Affairs benefits, Workers' Compensation, unemployment benefits or any other form of compensation? .....  Yes  No

If **yes**, please provide details i.e. when, amount, period paid, type of disability suffered, date claim finalised etc.


#### 4. Occupation details

Occupation

Describe all present duties in the table below (please complete both percentage of time and specific duties in all cases)

Type of work	% of time	Please describe your specific duties and where they are performed. Please note the examples below are to be used as a guide only.
Sedentary/administration		(e.g. filing, computer work, answering telephone, reception duties, etc.)
Manual work – light		(e.g. driving, warehousing, surveying, lifting under 5kgs, etc.)
Manual work – heavy		(e.g. bricklaying, lifting over 5kgs, painting, carpentry, mechanic, etc.)

How many hours do you work per week? .....

Annual salary (before tax) ..... \$   ,    ,

#### 5. Pastimes

Have you any intention of engaging in:

1. motorcycle/motor racing other than as a means of transportation to and from work? .....  Yes  No
2. any hazardous activities or sports, e.g. motor or water sports (such as canoeing), football, parachuting, recreations involving heights, underwater sports, caving, body contact sports, gliding, hang gliding etc? .....  Yes  No
3. aviation/flying, other than as a fare-paying passenger? .....  Yes  No

If you answered **yes** to any of questions 1, 2 or 3 above, please continue completing this section below for the relevant activity.

##### Motorcycle/motor racing

Vehicle type <input style="width: 250px;" type="text"/>	Races p.a. <input style="width: 250px;" type="text"/>
Engine size <input style="width: 250px;" type="text"/>	Max. speed (km/h) <input style="width: 250px;" type="text"/>
Class <input style="width: 250px;" type="text"/>	<input type="checkbox"/> Recreational <input type="checkbox"/> Amateur <input type="checkbox"/> Professional

##### Scuba/skin diving

Average depth (m) <input style="width: 250px;" type="text"/>	Maximum depth (m) <input style="width: 250px;" type="text"/>
Dives per annum <input style="width: 250px;" type="text"/>	Do you use explosives? <input style="width: 250px;" type="text"/>
Do you dive in caves or potholes? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No	

If **yes**, give details.


**Football/Soccer/Aussie Rules, etc.**

Code played and grade

Games p.a.   Recreational  Amateur  Professional

Do you receive any income participating in Football/Soccer/Aussie Rules etc.?

If **yes**, provide amount and details.

  


**Other sports or pastimes**

a. Please provide details and frequency of any other hazardous activities or sports you participate in (e.g. boxing, competitive riding, mountain climbing, body contact sports, caving, etc.).

If **yes**, provide frequency and details.

  


b. On what basis do you partake in this activity? .....  Recreational  Amateur  Professional

**Aviation/flying**

Do you hold a Civil Aviation Safety Authority (CASA) licence? .....  Yes  No

If **yes**, state type and period held.

Do you intend to change the scope of your present licence? .....  Yes  No

Have you ever had an accident or been charged with violating CASA regulations? .....  Yes  No

Do you always use authorised landing areas? .....  Yes  No

Please complete the table below.

No. of hours flown	Past 12 months		Future annual average	
	Crew	Passenger	Crew	Passenger
Commercial airline	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Charter	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Private	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Aero club/flying school	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Agriculture	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Helicopter	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Ultralight aircraft	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Do you intend to engage in any form of aviation other than the above categories (e.g. ballooning, aerobatics, parachuting, paragliding)? .....  Yes  No

If **yes**, please provide frequency and details.

## 6. Personal statement

1. What is your current height and weight? ..... Height (cm)  Weight (kg)

2. Has your weight varied by more than 10 kg during the last 12 months?.....  Yes  No

If **yes**, please provide details.

3. During the last 12 months have you smoked tobacco or any other substance?.....  Yes  No

If **yes**, please state **type** and **quantity** per day.

4. During the last three months, have you used nicotine replacement treatment?.....  Yes  No

If **yes**, please state **type** used and **duration** of use.

5. Non-smokers – have you ever smoked regularly in the past? .....  Yes  No

If **yes**, please state **type**, **quantity** per day and date ceased.

6. Do you consume alcohol?.....  Yes  No

If **yes**, please state **type** and **quantity** per day (the word 'social' is not sufficient).

7. Have you ever been advised to stop smoking or drinking alcohol on medical grounds? .....  Yes  No

If **yes**, please provide full details.

8. Has the virus which causes AIDS (the Human Immunodeficiency Virus) ever infected you or are you carrying antibodies to that virus?.....  Yes  No

9. Have you **ever** engaged in sexual activity with, or worked as, a prostitute; or engaged in anal sexual activity?.....  Yes  No  
If **yes**, a confidential questionnaire will be sent to you to complete and return to OnePath's underwriting department.

**If you are required to have a full medical examination, go to Section 9 on page 7.**

## 7. Family history

**To be completed for your blood relatives only (if adopted and family history unknown, please state so).**

1. Have any of your parents, brothers or sisters (alive or deceased) suffered from Huntington's disease, muscular dystrophy, cystic fibrosis, familial polyposis, polycystic kidney disease, Alzheimer's disease, dementia or any other hereditary or familial disorder?.....  Yes  No

2. Have any of your parents, brothers or sisters (alive or deceased) prior to age 60 been diagnosed with diabetes, heart disease, mental illness, haemophilia, haemochromatosis, high blood pressure, high cholesterol, breast cancer, cervical cancer, bowel cancer or any other cancer (please specify type), stroke or kidney disease?.....  Yes  No

If you answered **yes** to either question 1 or 2, please complete the following table.

Relation	Condition/Disorder	Age diagnosed
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

## 8. Medical history

To the best of your knowledge, have you ever had any of the following:

Please tick the appropriate box and circle the specific conditions that are applicable.

1. Asthma? .....  Yes  No
2. High blood pressure? .....  Yes  No
3. High cholesterol? .....  Yes  No
4. Diabetes? .....  Yes  No
5. Stress, anxiety, depression or any other mental health condition? .....  Yes  No
6. Back or neck pain, sciatica or any disorder of the spine or neck? .....  Yes  No
7. Arthritis, shoulder or knee pain or any other disorder of the joints? .....  Yes  No
8. Cyst, mole or skin lesion? .....  Yes  No

If you answered **yes** to any of the conditions in bold above, please complete the relevant questionnaire on pages 10 to 18.

9. Sleep apnoea, bronchitis, persistent cough or any other chest or lung condition? .....  Yes  No
10. Heart condition, murmur, chest pain, rheumatic fever, palpitations, stroke or vascular disorder? .....  Yes  No
11. Thyroid or glandular trouble? .....  Yes  No
12. Ulcers, bowel trouble or recurring indigestion? .....  Yes  No
13. Epilepsy, fits or dizziness of any kind or persistent headaches? .....  Yes  No
14. Alzheimer's disease or dementia? .....  Yes  No
15. Kidney, liver or bladder problems, renal colic or stones, nephritis, lupus nephritis, pyelitis or cystitis? .....  Yes  No
16. Broken bones or osteoporosis or any pain, strain or disorder of any muscles, ligaments, cartilage or limbs? .....  Yes  No
17. Gout, fibromyalgia, tendonitis, tenosynovitis, RSI, or any regional pain syndrome, chronic fatigue syndrome (myalgic encephalomyelitis)? .....  Yes  No
18. Cancer, tumour, growths of any kind or breast lumps (even if you have not seen a doctor)? .....  Yes  No
19. Varicose veins, hernia or skin trouble? .....  Yes  No
20. Any abnormality affecting eyesight, hearing or speech? .....  Yes  No
21. Any abnormality affecting physical mobility or muscular power (e.g. multiple sclerosis)? .....  Yes  No
22. Anaemia, haemophilia or any other disease of the blood? .....  Yes  No
23. Bowel, liver or gall bladder disease or hepatitis? .....  Yes  No
24. Coughing of blood or passing of blood from the bowel or in the urine? .....  Yes  No
25. Any sexually transmittable disease including but not limited to AIDS or its positive antibodies, gonorrhoea or syphilis? .....  Yes  No
26. Have you within the last five years had any other illness, injury, operation, X-ray, electrocardiogram, blood transfusion, any other special tests or been advised to have a blood test for any reason? .....  Yes  No
27. Due to injury or illness have you ever been off work for more than seven consecutive days (**if not already mentioned**)? .....  Yes  No
28. Do you now have any symptoms of ill health or disability? .....  Yes  No
29. Are you contemplating surgery, intending to consult a doctor, or have you been advised to have an operation in the future? .....  Yes  No
30. Do you take, or have you **ever** taken drugs or any medications on a regular or ongoing basis? .....  Yes  No
31. Have you **ever** used or injected any drugs not prescribed for you by a medical attendant? .....  Yes  No
32. Are you suffering from unintentional weight loss, persistent night sweats, persistent fever, diarrhoea or swollen glands? .....  Yes  No
- 33. Females only**
- a. Have you ever had any complications with pregnancy or childbirth? .....  Yes  No
- b. Are you now pregnant? If **yes**, please advise due date  .....  Yes  No
- c. Have you ever had an abnormal cervical smear test (pap), breast ultrasound or mammogram? .....  Yes  No
- d. Have you ever had any symptom(s) of, or sought advice or treatment for any condition of the cervix, ovary, uterus, breast, or endometrium? .....  Yes  No

If you answered **yes** to any questions from 9–33, please complete the following table. If there is not enough space here, please provide details on page 19.

Question number	Conditions or symptoms	Tests performed and results	Date started	Date ceased	Treatment and type, date provided and date ceased	Time off work	Have you fully recovered? Yes/No	Name and address of institution or health professional
			DD/MM/YYYY	DD/MM/YYYY				
			DD/MM/YYYY	DD/MM/YYYY				
			DD/MM/YYYY	DD/MM/YYYY				
			DD/MM/YYYY	DD/MM/YYYY				
			DD/MM/YYYY	DD/MM/YYYY				

## 9. Usual doctor or medical centre details

### 1. Full name and address of usual doctor/medical centre.

Doctor/Medical centre

Phone  Fax

No. and street

Suburb/Town  State  Postcode

How many years have you been attending this doctor/medical centre? .....years  months

2. Have you had any consultations with your usual doctor or any other doctor (other than for colds or the flu) in the last three years not already mentioned?.....  Yes  No

If **yes**, please provide details.

Name, address and phone number of doctor/medical centre	Date last consulted	Reason for check-up or consultation	Outcome including degree of recovery, medication, treatment, etc.
	DD/MM/YYYY		
	DD/MM/YYYY		
	DD/MM/YYYY		
	DD/MM/YYYY		

## 10. Declaration by the life insured or applicant

- I have read and understood the questions in this Personal Statement.
- I declare that the answers to the questions in this Personal Statement signed by me and given to OnePath Life and/or the Medical Examiner are true and correct.
- I authorise the collection, use and disclosure of my personal information for the purposes of administration and maintenance of this policy, as outlined in the Privacy Statement. I understand that OnePath Life will not be able to process a claim or administer this policy without this consent.
- I accept that where my employer (or former employer) or the Trustee of my superannuation fund has appointed a financial adviser or other intermediary to arrange and/or administer the Group Risk policy on their behalf, my personal information will be provided to the financial adviser/intermediary in order to undertake the management and administration of the policy.
- I declare that I have been clearly informed in writing of the general nature and effect of the duty of disclosure.
- I authorise any medical practitioner, other professional or any person named in this Personal Statement to verify any aspect of it, and disclose any information that they may possess about me to OnePath Life in relation to this insurance.
- I acknowledge that where I am making an application for insurance cover (or an increase in insurance cover), and where such application is made on a voluntary basis (other than as a direct result of the formula for cover which applies to the group risk policy or policies for which an application for cover is being made on the basis of this Personal Statement), that I have received, read and understood a copy of the Group Risk Product Disclosure Statement(s) (PDS) for the type(s) of cover for which I am applying.

Signature of life insured/applicant

Date

## 11. Authorisations

### Doctor's authorisation

To be completed and signed by the life insured.

#### Please sign authorisation

To doctor

I hereby authorise you to release details of my personal medical history to OnePath Life Limited ABN 33 009 657 176 AFSL 238341, or any organisation duly appointed by OnePath Life. A photocopy (or similar) of this authorisation shall be as valid as the original.

Name of life insured

Date of birth

Signature of life insured

Date

Address of life insured

State  Postcode

Policy number

### Doctor's authorisation

To be completed and signed by the life insured.

#### Please sign authorisation

To doctor

I hereby authorise you to release details of my personal medical history to OnePath Life Limited ABN 33 009 657 176 AFSL 238341, or any organisation duly appointed by OnePath Life. A photocopy (or similar) of this authorisation shall be as valid as the original.

Name of life insured

Date of birth

Signature of life insured

Date

Address of life insured

State  Postcode

Policy number

## 12. Privacy Statement

In this section 'we', 'us' and 'our' refers to OnePath Life and other members of the ANZ Group. We are committed to ensuring the confidentiality, security and privacy of your personal information. 'You' and 'your' refers to policy owners and life insureds.

We collect your personal information to provide you with the products and services you request. Without your personal information, we may not be able to process your application or provide you with the products or services you require.

In order to manage and administer the products and services requested by you, we may need to disclose your personal information to certain third parties, including:

- other members within the ANZ Group, to the extent necessary to service our relationship with you and carry on business as a group
- organisations performing administration or compliance functions in relation to the products and services
- organisations maintaining our information technology systems
- authorised financial institutions
- organisations providing services such as mailing, printing or data verification
- a person who acts on your behalf (such as your financial adviser or your agent)
- the policy owner (where you are a life insured who is not the policy owner).

For life risk products we collect health information with your consent. Your health information will only be disclosed to service providers, reinsurers or organisations providing medical or other services for the purpose of underwriting, assessing the application or assessing any claim.

We may also disclose your personal information in circumstances where we are required to do so by law.

We may send you information about our financial products and services from time to time. You may elect not to receive such information at any time by contacting Customer Services on 133 667.

You may access the personal information OnePath holds about you, subject to permitted exceptions and subject to OnePath still holding that information, by contacting OnePath at:

**Privacy Officer – OnePath**

GPO Box 75

Sydney NSW 2001

**Phone** 02 9234 8111

**Fax** 02 9234 8095

**Email** [privacy@onepath.com.au](mailto:privacy@onepath.com.au)

If any of your personal information is incorrect or has changed, please let OnePath know by contacting Customer Services.

More information can be found in OnePath's Privacy Policy which can be obtained from its website at [onepath.com.au](http://onepath.com.au)

### 13. Supplementary questionnaires

#### Asthma questionnaire

Only complete this questionnaire if you answered **yes** to question 1 in Section 8.

1. When did you have your first episode of asthma? ..... Date
2. When was your most recent episode of asthma? ..... Date
3. Approximately how many episodes have occurred in the last 12 months? .....
4. Have you had any time off work due to this condition? .....  Yes  No

If **yes**, please provide the dates and duration.

  


5. Are the symptoms/attacks typically precipitated by anything in particular (e.g. seasonal, exercise induced, a cold or bronchitis)? .....  Yes  No

If **yes**, please provide details.

6. Have you sought medical treatment or advice for asthma? .....  Yes  No

If **yes**, please provide details.

Name of doctor/health professional

Address

Suburb/Town  State  Postcode

Date of last consultation

7. How has your doctor described your asthma? .....  Mild  Moderate  Severe

8. Have you ever used any medication, including steroids? .....  Yes  No

If **yes**, please provide details.

Type	Date commenced	Frequency (e.g. daily, weekly)	Dosage	Date ceased (if applicable)	Reason for cessation
<input type="text"/>	<input type="text" value="DD/MM/YYYY"/>	<input type="text"/>	<input type="text"/>	<input type="text" value="DD/MM/YYYY"/>	<input type="text"/>
<input type="text"/>	<input type="text" value="DD/MM/YYYY"/>	<input type="text"/>	<input type="text"/>	<input type="text" value="DD/MM/YYYY"/>	<input type="text"/>
<input type="text"/>	<input type="text" value="DD/MM/YYYY"/>	<input type="text"/>	<input type="text"/>	<input type="text" value="DD/MM/YYYY"/>	<input type="text"/>
<input type="text"/>	<input type="text" value="DD/MM/YYYY"/>	<input type="text"/>	<input type="text"/>	<input type="text" value="DD/MM/YYYY"/>	<input type="text"/>

9. Have you ever been hospitalised due to asthma? .....  Yes  No

If **yes**, please provide details.

Date from  Date to

Name and address of hospital.

  


10. Have you ever had lung function tests performed? .....  Yes  No

If **yes**, please provide details.

Date	Test results
<input type="text" value="DD/MM/YYYY"/>	<input type="text"/>
<input type="text" value="DD/MM/YYYY"/>	<input type="text"/>
<input type="text" value="DD/MM/YYYY"/>	<input type="text"/>

**Blood pressure questionnaire**

Only complete this questionnaire if you answered **yes** to question 2 in Section 8.

1. When was your high blood pressure first diagnosed? ..... Date
2. What was your blood pressure reading at that time? ..... Systolic  Diastolic
3. Have you ever been treated by medication? .....  Yes  No

If **yes**, please provide details.

Type	Date commenced	Frequency (e.g. daily, weekly)	Dosage	Date ceased (if applicable)	Reason for cessation
<input type="text"/>	<input type="text" value="DD/MM/YYYY"/>	<input type="text"/>	<input type="text"/>	<input type="text" value="DD/MM/YYYY"/>	<input type="text"/>
<input type="text"/>	<input type="text" value="DD/MM/YYYY"/>	<input type="text"/>	<input type="text"/>	<input type="text" value="DD/MM/YYYY"/>	<input type="text"/>
<input type="text"/>	<input type="text" value="DD/MM/YYYY"/>	<input type="text"/>	<input type="text"/>	<input type="text" value="DD/MM/YYYY"/>	<input type="text"/>
<input type="text"/>	<input type="text" value="DD/MM/YYYY"/>	<input type="text"/>	<input type="text"/>	<input type="text" value="DD/MM/YYYY"/>	<input type="text"/>

4. Did you undergo any tests or investigations? .....  Yes  No

If **yes**, please provide details.

Tests performed	Date	Results
<input type="text"/>	<input type="text" value="DD/MM/YYYY"/>	<input type="text"/>
<input type="text"/>	<input type="text" value="DD/MM/YYYY"/>	<input type="text"/>

5. Is the treating doctor different to your usual doctor? .....  Yes  No

If **yes**, please provide details.

Name

Address

Suburb/Town  State  Postcode

Date of last consultation

6. What was the date of your last blood pressure check? .....

7. What was your blood pressure reading at that time? ..... Systolic  Diastolic

8. How has your doctor described your blood pressure control? .....  Excellent  Good  Poor  Other

If **other**, please provide details.

9. What is the date of your next blood pressure check-up? ..... Date

## Cholesterol questionnaire

Only complete this questionnaire if you answered **yes** to question 3 in Section 8.

1. When was your high cholesterol first diagnosed? ..... Date

2. What were your cholesterol readings at that time? ..... Cholesterol  Triglycerides   
 HDL Cholesterol  LDL Cholesterol

3. Did you undergo any tests or investigations? .....  Yes  No

If **yes**, please provide details.

Tests performed	Date	Results
<input type="text"/>	<input type="text" value="DD/MM/YYYY"/>	<input type="text"/>
<input type="text"/>	<input type="text" value="DD/MM/YYYY"/>	<input type="text"/>

4a. Have you ever used any medication? .....  Yes  No

If **yes**, please provide details.

Type	Date commenced	Frequency (e.g. daily, weekly)	Dosage	Date ceased (if applicable)	Reason for cessation
<input type="text"/>	<input type="text" value="DD/MM/YYYY"/>	<input type="text"/>	<input type="text"/>	<input type="text" value="DD/MM/YYYY"/>	<input type="text"/>
<input type="text"/>	<input type="text" value="DD/MM/YYYY"/>	<input type="text"/>	<input type="text"/>	<input type="text" value="DD/MM/YYYY"/>	<input type="text"/>
<input type="text"/>	<input type="text" value="DD/MM/YYYY"/>	<input type="text"/>	<input type="text"/>	<input type="text" value="DD/MM/YYYY"/>	<input type="text"/>
<input type="text"/>	<input type="text" value="DD/MM/YYYY"/>	<input type="text"/>	<input type="text"/>	<input type="text" value="DD/MM/YYYY"/>	<input type="text"/>

4b. Has this treatment ever changed (e.g. has the type or dosage of your medication been changed)? .....  Yes  No

If **yes**, please provide date of when treatment changed and the reason(s) for change.

5. Is the treating doctor different to your usual doctor? .....  Yes  No

If **yes**, please provide details.

Name

Address

Suburb/Town  State  Postcode

Date of last consultation

6. What was the date of your last cholesterol check? ..... Date

7. What were your cholesterol readings at that time? ..... Cholesterol  Triglycerides   
 HDL Cholesterol  LDL Cholesterol

8. How has your doctor described your cholesterol control? .....  Excellent  Good  Poor  Other

If **other**, please provide details.

9. What is the date of your next cholesterol check-up? ..... Date

**Diabetes questionnaire**

Only complete this questionnaire if you answered **yes** to question 4 in Section 8.

1. When was your diabetes first diagnosed? ..... Date

2. How is your diabetes controlled?

- Insulin – go to question 3
- Diet only – go to question 4
- Oral – list medications below and then go to question 4


3. How many times a day do you administer insulin? .....  I'm on an insulin pump  One or two times daily  Three or more times daily

4. How often do you monitor your sugar levels? .....  One or two times daily  Three or more times daily  Other

If **other**, please provide details.

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5. Have you ever had insulin reactions, diabetic coma, heart, kidney, peripheral vascular disease or eye problems (not already mentioned in the Personal Statement), or protein in the urine? .....  Yes  No

If **yes**, please provide details.

Condition	Date	Treatment
	<input type="text" value="DD/MM/YYYY"/>	
	<input type="text" value="DD/MM/YYYY"/>	

6. Have you had a glycosylated haemoglobin (HbA1c) test in the last six months? .....  Yes  No

If **yes**, please provide details.

Date	Test results
<input type="text" value="DD/MM/YYYY"/>	
<input type="text" value="DD/MM/YYYY"/>	

Is this result consistent with others taken over the last 12 months? .....  Yes  No

If **no**, please provide details.

Date	Test results
<input type="text" value="DD/MM/YYYY"/>	
<input type="text" value="DD/MM/YYYY"/>	

7. Is the treating doctor different to your usual doctor? .....  Yes  No

If **yes**, please provide details.

Name

Address

Suburb/Town  State  Postcode

Date of last consultation

**Mental health questionnaire**

Only complete this questionnaire if you answered **yes** to question 5 in section 8.

**1.** Please tick the conditions you have had (or currently have), or received treatment for:

- Anxiety including generalised anxiety, panic or phobia disorder
- Eating disorder including anorexia nervosa or bulimia
- Depression including major depression or dysthymia
- Manic depressive illness or bi-polar disorder
- Alcohol or other substance abuse or addiction
- Post traumatic stress
- Schizophrenia or any other psychotic disorder
- Stress, sleeplessness or chronic tiredness
- Other

If **other**, please describe.

**2.** Please complete the table below for all described conditions.

Condition	Describe your symptoms	Date diagnosed	Date condition ceased (if applicable)
<input style="width: 95%; height: 20px;" type="text"/>	<input style="width: 95%; height: 20px;" type="text"/>	<input style="width: 95%; height: 20px;" type="text"/>	<input style="width: 95%; height: 20px;" type="text"/>
<input style="width: 95%; height: 20px;" type="text"/>	<input style="width: 95%; height: 20px;" type="text"/>	<input style="width: 95%; height: 20px;" type="text"/>	<input style="width: 95%; height: 20px;" type="text"/>
<input style="width: 95%; height: 20px;" type="text"/>	<input style="width: 95%; height: 20px;" type="text"/>	<input style="width: 95%; height: 20px;" type="text"/>	<input style="width: 95%; height: 20px;" type="text"/>
<input style="width: 95%; height: 20px;" type="text"/>	<input style="width: 95%; height: 20px;" type="text"/>	<input style="width: 95%; height: 20px;" type="text"/>	<input style="width: 95%; height: 20px;" type="text"/>

**3.** Have you ever had any recurrence of the symptoms? .....  Yes  No

If **yes**, please provide details including dates.

  


**4.** Are you currently symptom free? .....  Yes  No

If **yes**, please provide date(s) of last symptoms.

**5.** Have you ever attempted suicide or self harm? .....  Yes  No

If **yes**, please provide details including when, name and address of treating doctor, clinic or hospital.

  


**6.** Are you aware of the cause or reason for your condition(s)? .....  Yes  No

If **yes**, please provide details.

  


**7.** Have you ever had any time off work due to your condition(s)? .....  Yes  No

If **yes**, please provide the dates and duration.

  


**8.** Are you currently or have you ever been on treatment, including medication? .....  Yes  No

If **yes**, please provide details.

Treatment (e.g. tranquillisers, sedatives, ECT, counselling, etc.)	Date commenced	Date ceased (if applicable)	Reason ceased
<input style="width: 95%; height: 20px;" type="text"/>	<input style="width: 95%; height: 20px;" type="text"/>	<input style="width: 95%; height: 20px;" type="text"/>	<input style="width: 95%; height: 20px;" type="text"/>
<input style="width: 95%; height: 20px;" type="text"/>	<input style="width: 95%; height: 20px;" type="text"/>	<input style="width: 95%; height: 20px;" type="text"/>	<input style="width: 95%; height: 20px;" type="text"/>

9. Do you feel that your condition(s) has had any impact on your ability to perform your job at work or on your social life? .....  Yes  No

If **yes**, please provide details.


10. Have you been referred for consultation with a psychiatrist or psychologist? .....  Yes  No

If **yes**, please provide details.

Name of consultant					
Address					
Suburb/Town		State		Postcode	
Date of last consultation	DD/MM/YYYY				

11. Have you been admitted to hospital or any other care facility? .....  Yes  No

If **yes**, please provide details.

Name of institution					
Address					
Suburb/Town		State		Postcode	
Date of last consultation	DD/MM/YYYY	Doctor(s) consulted			

Back/Neck questionnaire

Only complete this questionnaire if you answered **yes** to question 6 in Section 8.

1. When did your back/neck condition first occur? ..... Date

2. Which area(s) of your back/neck was affected (e.g. middle back)?

3. What was the cause or reason for the condition?

4. Please describe the exact nature of the condition, including the symptoms and doctor's diagnosis if known (e.g. sciatica, prolapsed disc, whiplash etc.):

5. Was an X-ray, CT scan or any other type of investigation performed? .....  Yes  No

If **yes**, please provide details.

Tests	Date of tests	Results
<input type="text"/>	<input type="text" value="DD/MM/YYYY"/>	<input type="text"/>
<input type="text"/>	<input type="text" value="DD/MM/YYYY"/>	<input type="text"/>

6. Have you had recurrent or multiple episodes of the back/neck condition? .....  Yes  No

If **yes**, please provide details including the number of episodes and the date of the most recent episode including duration.

7. Please provide details of all people you have consulted for this condition in the table below.

Name and address of doctor/health professional	Type (e.g. doctor, chiropractor, physiotherapist)	Date last consulted	Treatment prescribed (e.g. analgesics, anti-inflammatory drugs, immobilisation)
<input type="text"/>	<input type="text"/>	<input type="text" value="DD/MM/YYYY"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text" value="DD/MM/YYYY"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text" value="DD/MM/YYYY"/>	<input type="text"/>

8. Have you had any time off work due to this condition? .....  Yes  No

If **yes**, please provide the dates and duration.

9. Are your work duties or activities limited/affected by the condition? .....  Yes  No

If **yes**, please provide details.

10. Are you still undergoing treatment or do you have any residual pain, limitation of movement or restriction of any kind? .....  Yes  No

If **yes**, please provide details.

11. Overall do you feel that your back/neck condition is: .....  Resolved  Improving  Stable  Deteriorating

12. What was the date of your last symptoms? ..... Date

**Arthritis/Joint questionnaire**

Only complete this questionnaire if you answered **yes** to question 7 in Section 8.

1. Which joint is/was affected (please tick relevant box/es)? If more than one box is ticked, please copy this questionnaire and complete for each condition.

	<b>Left</b>	<b>Right</b>		<b>Left</b>	<b>Right</b>
Ankle	<input type="checkbox"/>	<input type="checkbox"/>	Wrist	<input type="checkbox"/>	<input type="checkbox"/>
Elbow	<input type="checkbox"/>	<input type="checkbox"/>	Hip	<input type="checkbox"/>	<input type="checkbox"/>
Shoulder	<input type="checkbox"/>	<input type="checkbox"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>
Knee	<input type="checkbox"/>	<input type="checkbox"/>	If <b>other</b> , state which joint		

2. When did this condition first occur? ..... Date

3. What was the cause or reason for the condition?

4. Please describe the exact nature of the condition, including symptoms and doctor's diagnosis if known.

5. Have you had recurrent or multiple episodes of the condition? .....  Yes  No  
 If **yes**, please provide details including the number of episodes and the date of the most recent episode including duration.

6. Please provide details of all people you have consulted for this condition in the table below.

Name and address of doctor/health professional	Type (e.g. doctor, chiropractor, physiotherapist)	Date last consulted	Treatment prescribed (e.g. steroids, anti-inflammatory drugs, surgery, acupuncture)
		DD/MM/YYYY	
		DD/MM/YYYY	
		DD/MM/YYYY	

7. Have you had any time off work due to this condition? .....  Yes  No  
 If **yes**, please provide the dates and duration.

8. Do you have any residual pain, limitation of movement or restriction of any kind? .....  Yes  No  
 If **yes**, please provide details.

9. Are your work duties or activities limited/affected by the condition?.....  Yes  No  
 If **yes**, please provide details.

10. Are you still undergoing treatment? .....  Yes  No  
 If **yes**, please provide details.

11. Overall do you feel that your condition is:.....  Resolved  Improving  Stable  Deteriorating

12. What was the date of your last symptoms?..... Date

## Cyst/Mole/Skin lesion questionnaire

Only complete this questionnaire if you answered **yes** to question 8 in Section 8.

1. Please provide details in the table below.

Site (e.g. back, left leg)	Date diagnosed	Type (e.g. basal cell carcinoma, melanoma, cyst, mole)	Pathology results (e.g. malignant, benign, unknown)
	DD/MM/YYYY		
	DD/MM/YYYY		
	DD/MM/YYYY		

2. Was the cyst/mole/skin lesion(s) removed? .....  Yes  No

If **yes**, please provide details for each ..... Date of removal

By what method (e.g. surgically, frozen or burnt off)?

  

  


If **no**, please provide details including date set for removal, if applicable.

  


3. Have you been or are you required to attend any further treatment or regular follow up since the original removal? .....  Yes  No

If **yes**, please provide details and advise how often follow up is required.

  


4. Have you had any other tests, investigations or treatments not mentioned above? .....  Yes  No

If **yes**, please provide details.

Tests/Treatments/Investigations	Date	Results
	DD/MM/YYYY	
	DD/MM/YYYY	
	DD/MM/YYYY	

5. Is the treating doctor different to your usual doctor? .....  Yes  No

If **yes**, please provide details.

Name

Address

Suburb/Town  State  Postcode

Date of last consultation



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