Early Intervention in Chronic Disease - Intake Questions

SURNAME:……………..UR NUMBER:……….

GIVEN NAME:…………………………………….

AGE:…………. SEX: M / F

VMO:……………………………………

USE LABEL IF APPLICABLE

"As part of the referral process there are several questions that I need to ask you prior to your visit. These questions help our clinician [or assessment officer] in understanding your current health status. The following 9 questions are about any long term illness that you may have."

Has a doctor or other health professional ever told you that you have any of the following conditions?

Yes	No	Tick boxes, please do not leave response blank!!!
		A. Cardiovascular disease (including hear attack, stroke, poor circulation, angina or heart operations) Please identity conditions:…………………………………………………………………………
		B. Diabetes Mellitus (Type II) Other type of Diabetes?..
		C. Cancer (please specify)………………………………………………………………………… Do you currently have cancer? ☐ Yes ☐ No Are you in remission? ☐ Yes ☐ No
		D. Respiratory conditions (Asthma, COPD, Emphysema) Please identify type:……………………………………………………………………………... Do you currently smoke? ☐ Yes ☐ No
		E. Musculoskeletal conditions (including Rheumatoid or Osteoarthritis, Osteoporosis, Lupus, Fibromyalgia) Please identify type:……………………………………………………………………………...
		F. Visual, Hearing, Functional Impairment Please identity impairment:…………………………………………………………………….
		G. Mental Illness (Depression, Anxiety, Bi-Polar, Schizophrenia) Please identity type:…………………………………………………………………………….
		H. Hypertension (high blood pressure)
		I. Dental problems (extractions, pain, dentures) Please identity problem:……………………………………………………………………….
		J. Other (condition not stated / comment)

Signature:…………………………………………………	Name:……………………………………………………
Designation:………………………………………………	Date:…………………………………………………….