



QUESTIONNAIRE: HYPERCHOLESTEROLAEMIA
(RAISED CHOLESTEROL)

Name:

Date of birth:

Application reference:.....

1. Was the condition diagnosed in the last 12 months? YES / NO
2. Are you prescribed more than ONE medication to control this condition (excluding aspirin)? YES / NO
3. If you are not on any medication, have you ever been recommended to take medication to control this condition? YES / NO
4. Are you under the care of a consultant? YES / NO
5. Has the dosage of your medication increased in the last 12 months? YES / NO
6. Have you ever had any heart disorders, diabetes or renal / kidney impairment? YES / NO

Declaration

I declare that, to the best of my knowledge and belief, the answers to the above questions are true and complete.

Signature:**Date:**

(Of the person named above, or the main applicant if that person is a child under the age of 16)