Tommy's National Centre for Miscarriage Research

University Hospitals Coventry and Warwickshire NHS Trust

Registration form

Male details

Title	**Date of birth**	
Surname	**Ethnic group (see last page)***	
First and forename(s)	**Religion (see last page)***	
Address	**Marital status (see last page)***	
	Education (see last page)*	
	Occupation	
	NHS number	
	Hospital number	
City/town	**GP name**	
County	**GP address**	
Telephone (Home)		
Telephone (Mobile)	**GP telephone**	
E-mail address (we will use this to correspond with you):		

*** -** enter the relevant code from the list of tables on the last page of this form

Data Disclosure and Protection: By completing this form, you hereby give your consent for the data to be held within the NHS in accordance with the requirements of the 1998 Data Protection Act (UK).

Male signature:	
Date:	

Shields R, *et al. BMJ Open* 2022; 12:e052661. doi: 10.1136/bmjopen-2021-052661

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Please complete this form with as much information as you are able to. If you are uncertain about any of the questions you will be able to check these with your healthcare provider at your clinic appointment. Please include all medical information in your history even if you think it may be unimportant.

Previous illnesses or medical problems

	Yes	No
Have you had any serious illnesses or medical problems?	☐	☐

If yes, tick all applicable:

Diabetes	☐	Rheumatism or painful joints	☐
Thyroid problems	☐	Skin rashes or other skin disorders	☐
Cancer	☐	Irritable Bowel Syndrome	☐
Heart problems	☐	Coeliac disease	☐
Liver problems	☐	Crohn's disease	☐
Migraines	☐	Autoimmune disease	☐
Epilepsy	☐	Other inflammatory disorder	☐
Depression	☐	Thrombosis (clot in the leg or chest)	☐
High blood pressure	☐	Candida	☐
Lupus (SLE)	☐	Bacterial urethritis	☐
		Abnormal urethral discharge	☐

Other illnesses ☐ Please state: _____

If you have ticked any of the boxes above, please provide further details below:

Current medications and allergies

Please provide details on any allergies you have and medication you are currently taking below:

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Andrological history

Have you had a testicular examination before? Yes ☐ No ☐

What was found? _____

Have you had any of the following diagnosed?

Please tick all applicable options

Absence of a testicle (cryptorchidism)	☐	Mumps	☐
Testicular pain	☐	Tuberculosis (TB)	☐
Twisted testicles (torsion)	☐	Impotence/erectile dysfunction	☐
Testicular cancer	☐	Ejaculatory dysfunction	☐
Varicose veins in your scrotum	☐	Infertility	☐
		STI's	☐

If you have ticked any of the boxes above, please provide further details below:

Have you had any of the following surgeries?

Please tick all applicable options

Groin surgery	☐
Varicocelectomy	☐
Orchidectomy	☐
Orchidopexy	☐
Surgery for hernia	☐

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Family medical problems

Has your mother, father, siblings or maternal aunt(s) had any medical complications? Yes ☐ No ☐

If yes, tick all applicable:

- Miscarriage ☐
- Recurrent (3 or more) miscarriages ☐ → *If yes:* Number of 1st trimester losses (<12 weeks) ☐☐ Number of 2nd trimester losses (>12 weeks) ☐☐ ☐ I don't know
- Obstetric complications (such as pre-eclampsia and growth restriction) ☐
- Genetic or developmental problems ☐
- Heart problems under the age of 50 ☐
- Stroke under the age of 50 ☐
- Still birth ☐
- Pre-term birth ☐
- Infertility ☐
- High blood pressure ☐
- Diabetes ☐
- Blood clots (thrombosis) ☐
- Depression ☐
- Other ☐

Please state: _____

If you have ticked any of the boxes above, please provide further details below:

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Previous paternal history

	Yes	No
Have you had children in another relationship?	☐	☐
If yes, number of children: ☐☐		
Have you ever had a delay (>12 months) trying to father a child?	☐	☐

What age did you enter puberty? ☐☐ years

What is your current average ejaculatory frequency per week? ☐☐☐ times/week

What is your usual ejaculatory frequency per month (4 weeks)? ☐☐☐ times/month

Occupational exposure

	Yes	No
Have you been exposed to any harmful substances during your current or previous jobs? (see below for examples of such substances)	☐	☐

Exposure Type/Substance: (Years of exposure)

Dust	☐☐	Asbestos	☐☐
Fumes	☐☐	Noxious Gases	☐☐
Harmful vapours	☐☐	Chemicals	☐☐

Other (please specify): _____

Please provide further details:

_____

_____

_____

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Typeofunderwear

What type of underwear do you wear?

Tick one option

- Boxer shorts ☐
- Boxer briefs/trunks ☐
- Briefs ☐
- Thongs/Bikinis/G-strings ☐
- Long underwear ☐
- Jockstraps ☐
- None ☐

What type of fabric is the underwear most commonly made from?

Tick one option

- Cotton ☐
- Synthetic ☐
- Lycra ☐
- Other (please specify) ☐ _____

Do they hold your testicles to the body, or are they loose?

Tick one option

- Tight ☐
- Loose ☐
- Unsure ☐

Is the tightness of your underwear similar to before the last time your partner fell pregnant?

Tick one option

Yes ☐ No ☐ Don't know ☐

Technology habits

Do you ever sit with a laptop computer on your lap? Yes ☐ No ☐

↓

How many hours per day? ☐☐ hours ☐☐ minutes

Do you keep your mobile phone (that's switched on) in your trouser pocket?

Front pocket? Yes ☐ No ☐

↓

How many hours a day? ☐☐ hours/day

Back pocket? Yes ☐ No ☐

↓

How many hours a day? ☐☐ hours/day

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Diet and supplements

How many days a week do you eat the following foods:

Tick one box per food type

	Number of days per week							
	0	1	2	3	4	5	6	7
Red meat	☐	☐	☐	☐	☐	☐	☐	☐
White meat	☐	☐	☐	☐	☐	☐	☐	☐
Fish	☐	☐	☐	☐	☐	☐	☐	☐
Eggs	☐	☐	☐	☐	☐	☐	☐	☐
Fresh fruit	☐	☐	☐	☐	☐	☐	☐	☐
Fresh vegetables	☐	☐	☐	☐	☐	☐	☐	☐
Dairy products	☐	☐	☐	☐	☐	☐	☐	☐
Soya products	☐	☐	☐	☐	☐	☐	☐	☐
Chocolate	☐	☐	☐	☐	☐	☐	☐	☐
Nuts (almonds/walnuts)	☐	☐	☐	☐	☐	☐	☐	☐

Do you consume sugar substitutes daily or most days of the week? ☐ Yes ☐ No

How many cups of coffee* do you drink in a typical day? ☐ cups of coffee/day

How many cups of tea* do you drink in a typical day? ☐ cups of tea/day

How many cans (or equivalent) of soft drink do you consume per day (e.g. energy drinks, cola)? ☐ cans/day

Do you currently take any vitamins or supplements? ☐ Yes ☐ No

If yes, please provide details:

	Name of product	**Frequency (times/week)**	**How long have you been taking it? (weeks)**
1			
2			
3			
4			

* Do not count decaffeinated drinks

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Diet and supplements

If you are not taking vitamins or minerals currently but have taken them in the last four months please complete this table.

	Name of product	Frequency (times/week)	Duration (weeks)
1			
2			
3			
4			

Are you currently taking any protein shakes or protein bars? ☐ Yes ☐ No

If yes, please provide details:

	Name of product	Frequency (times/week)	Duration (weeks)
1			
2			
3			
4			

Exercise

Do you follow a regular routine of physical exercise? ☐ Yes ☐ No

How many days a week do you exercise?

Tick one option

0 ☐
1-2 ☐
3-4 ☐
5-6 ☐
7 ☐

If you exercise, how many hours a day do you exercise?

Tick one option

< 30 min ☐
30 min - 1 hr ☐
1 hr - 1.5 hrs ☐
1.5 hrs - 2 hrs ☐
2 hrs - 2.5 hrs ☐
> 2.5 hrs ☐

On average how many hours do you spend sitting on a chair per day?

Sofa or armchair ☐ hours/day Work chair ☐ hours/day

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Recreational drug use

Do you currently drink alcohol? Yes ☐ No ☐

How many units per week? ☐☐ units per week

Do you currently smoke? Yes ☐ No ☐

If yes:

How many cigarettes? ☐☐ per day **or** ☐☐ per week

How many vaping sessions? ☐☐ per day **or** ☐☐ per week
One session is classified as 5 or more inhalations

If no:

Have you recently stopped? ☐ Yes ☐ No

If yes, how recently did you stop? ☐ < 1 month ☐ 1-6 months ☐ > 6 months

Do you take any other recreational drugs? Yes ☐ No ☐

If yes, please complete table:

Type	Frequency of use (tick one option)
	☐ Daily ☐ 2-3 times per week ☐ Weekly ☐ Bi-weekly ☐ Monthly ☐ Every 2-3 months ☐ Every 6 months
	☐ Daily ☐ 2-3 times per week ☐ Weekly ☐ Bi-weekly ☐ Monthly ☐ Every 2-3 months ☐ Every 6 months
	☐ Daily ☐ 2-3 times per week ☐ Weekly ☐ Bi-weekly ☐ Monthly ☐ Every 2-3 months ☐ Every 6 months
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Tests and investigations

Please give details of any tests or investigations you've had as a part of your treatment.

Test/investigations	Date of test	Result	Which hospital or clinic did you have the test at?
Semen analysis			
Sexually transmitted infection screening			

If other tests, please state below:

Test/investigation	Date of test	Result	Which hospital or clinic did you have the test at?

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Treatments

Please give details of any treatments you've previously received or are currently receiving as a part of your miscarriage management.

Please also include any medications that you've bought yourself.

Treatment (please include medicines and operations)	Dose	Date from*	Date to	Tick if ongoing	Additional clinician's notes
				☐	
				☐	
				☐	
				☐	
				☐	
				☐	
				☐	
				☐	

* If an operation, please give the date of operation

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Examination

This section should be completed in conjunction with the a member of the research team who attends to you in the clinic

Weight: ☐☐☐ kg Height: ☐☐☐ cm BMI: ☐☐.☐

Blood pressure: ☐☐☐ / ☐☐☐ mmHg
Systolic Diastolic

Examination findings (if appropriate)

For Tommy's research office use only if patient is consented and registered to take part in Tommy's research

Date of consent: d d - m m m - y y y y

Patient ID: ☐☐☐☐ - P A T

Recruiting site:

Date entered onto database: __/___/____ Entered by: Date checked: __/___/____ Checked by:

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Ethnicity codes

WHITE		**Category includes**
A	White British	English, Scottish, Welsh, Cornish
B	White Irish	
C	Any other white background	Former USSR, Baltic States, Former Yugoslavia, Other European, White South African, American, Australian, New Zealander, Mixed White
CF	Greek	
CG	Greek Cypriot	
CH	Turkish	
CI	Mediterranean	Italian, Portuguese and Spanish
CJ	Turkish Cypriot	
CN	Jewish	
CY	Other White European	
MIXED		
D	White & Black Caribbean	
E	White & Black African	
F	White & Asian	
G	Any other mixed background	
ASIAN OR ASIAN BRITISH		
H	Indian	British Indian, Punjabi
J	Pakistani	British Pakistani, Kashmiri
K	Bangladeshi	British Bangladeshi
L	Any other Asian background	British Asian, East African Asian, Sri Lankan, Tamil, Sinhalese, Caribbean Asian, Nepalese, Mixed Asian
BLACK OR BLACK BRITISH		
M	Black Caribbean	Caribbean, West Indian Islands (and also Guyana) apart from Puerto Rican, Dominican and Cuban, which are Latin America
N	Black African	Nigerian, Kenyan, Black South African, Other Black African Countries
P	Other Black background	Black American, Mixed Black
PA	Somali	
PE	Black British	
OTHER ETHNIC GROUPS		
R	Chinese	inc. Hong Kong
S	Any other ethnicity	Japanese, Filipino, Malaysian, Aborigine, Afghani, Burmese, Fijian, Inuit, Maori, Native American Indian, Thai, Tongan, Samoan, Iranian, Israeli, Kurdish, Latin American (inc. Cuban, Puerto Rican, Dominican, Hispanic), Moroccan, Multi Ethnic Islands (inc. Seychellois, Maldivian, St. Helena), Other Middle Eastern (inc. Iraqi, Lebanese, Yemeni), Other North African, South American (inc. Central America).
SA	Africa—colour not defined	
SC	Arab	
SD	Vietnamese	
Z	Not stated	

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Religion codes

A	Christian (all denominations)
B	Buddhist
C	Hindu
D	Jewish
E	Muslim
F	Sikh
G	Agnostic
H	Atheist
I	I'd rather not say
J	Other (please specify)

Marital status codes

A	Single
B	Married
C	Separated
D	Divorced
E	Widowed

Education codes

A	No formal qualifications
B	1-4 GCSEs (A*-C) or equivalent
C	5+ GCSEs (A*-C) or equivalent
D	Apprenticeship
E	2+ A-levels or equivalent
F	Degree or above
G	Other (please specify)

Tommy's Net questionnaire (Male) v2.1 26/06/2017

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University Hospitals Coventry and Warwickshire NHS Trust

Registration form

Female details

Title	**Date of birth**	
Surname	**Ethnic group (see last page)***	
First and forename(s)	**Religion (see last page)***	
Address	**Marital status (see last page)***	
	Education (see last page)*	
	Occupation	
	NHS number	
	Hospital number	
City/town	**GP name**	
County	**GP address**	
Telephone (Home)		
Telephone (Mobile)	**GP telephone**	
E-mail address (we will use this to correspond with you):		

*** -** enter the relevant code from the list of tables on the last page of this form

Data Disclosure and Protection: By completing this form, you hereby give your consent for the data to be held within the NHS in accordance with the requirements of the 1998 Data Protection Act (UK).

Female signature:	
Date:	

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Please complete this form with as much information as you are able to. If you are uncertain about any of the questions you will be able to check these with your healthcare provider at your clinic appointment. Please include all medical information in your history even if you think it may be insignificant.

Relationship details

What is the length of your current relationship? ☐☐ years ☐☐ months

	Yes	No
Are you and your partner blood relatives?	☐	☐

Please describe: _

Menstrual period and pregnancy information

What was the first date of your last menstrual period? d d - m m - y y y y

What age did your periods start? ☐☐ years

	Yes	No
Are your periods regular?	☐	☐

If yes, what is your cycle length (time from the beginning of one period to the beginning of the next)? ☐☐ days

If no, what is your cycle length? **MIN** ☐☐ days

MAX ☐☐ days

How many days do you bleed for? ☐☐ days

Do you get any bleeding in between your periods?	☐	☐
Do you have any problems with intercourse?	☐	☐

How frequently do you have intercourse? ☐☐ per/wk

or ☐☐ per/month

Have you ever had a delay (>12 months) in trying to get pregnant?	☐	☐
Are you currently pregnant?	☐	☐
Are you currently trying to become pregnant?	☐	☐

How long have you been trying to conceive? ☐☐ years ☐☐ months

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Contraception and fertility treatment

*Please complete the table below with all forms of contraception you have previously used (e.g. coil (IUCD), Depo-Provera injection, oral contraceptive pill). Use of condoms **DOES NOT** need to be included.*

Type of contraception	How long did you use it (years)?	How long ago did you stop using it (years)?

Yes No

Have you ever used fertility treatment to try and get pregnant? ☐ ☐

↓

Please tick all treatments you've had, and enter the number of attempts

Clomid/other ovary stimulation ☐ ☐☐ attempts

IVF/ICSI ☐ ☐☐ attempts

IUI ☐ ☐☐ attempts

Donor sperm treatment ☐ ☐☐ attempts

Donor egg treatment ☐ ☐☐ attempts

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Previous pregnancies

*Use the key opposite to complete the fields marked with *. If year or gestation are not known, state NK in the relevant box*

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Year	Gestation (wks)	Time taken to get pregnant (months)	Method of conception*	Any ultrasound scan findings? (e.g. please tell us if the baby's heart-beat was seen)	Sex (M or F, if known)	Outcome** (enter code)	If miscarriage, type of management*** (enter code)	Mode of delivery**** (enter code)	With current partner (Yes or No)	Additional clinician's notes

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*** Method of conception**

1	Natural
2	IVF/ICSI
3	IUI
4	Donor sperm treatment
5	Donor egg treatment
6	Ovarian stimulation

****Outcome**

1	Live birth
2	Stillbirth
3	Pregnancy loss without ultrasound confirmation of pregnancy
4	Miscarriage after ultrasound confirmation of pregnancy
5	Late miscarriage (>12 weeks to <24 weeks)
6	Ectopic pregnancy
7	Molar pregnancy
8	Resolved pregnancy of unknown location
9	Termination

*****Type of management**

1	Expectant (waited for nature to take its course)
2	Surgical (operation)
3	Medical (took a tablet(s))

****** Mode of delivery**

1	Unassisted vaginal
2	Instrumental vaginal (forceps or suction cup delivery)
3	Elective caesarean section
4	Emergency caesarean section
5	Vaginal breech
6	Not applicable

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Previous pregnancy-related complications

	Yes	No
Do you have a history of polycystic ovaries?	☐	☐
Do you have a history of fibroids?	☐	☐

If yes: Distorting womb cavity ☐
Not distorting womb cavity ☐
I don't know ☐

	Yes	No
Do you have a history of endometriosis?	☐	☐
Do you have a history of pelvic inflammatory disease?	☐	☐
Do you have a history of uterine (womb) abnormalities?	☐	☐
Have you ever had a sexually transmitted disease?	☐	☐
If yes, when: m m - y y y y Was it treated?	☐	☐
Have you ever had any previous gynaecological surgeries?	☐	☐

If yes, tick all applicable:

Laser or loop excision of the cervix (LLETZ)	☐ →	If yes, how many operations? ☐☐ operations	
Removal of fibroids	☐	Removal of scar tissues in the womb	☐
Endometriosis surgery	☐	Womb septum removal	☐
Fallopian tube surgery	☐	Other gynaecological surgeries	☐ If yes, state: _____
Removal of ovarian cyst(s)	☐	Other gynaecological disorders	☐ If yes, state: _____
Surgical management of miscarriage	☐	I don't know	☐

Date of last cervical smear test? m m - y y y y

Result? ☐ Normal ☐ Abnormal

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Recreational drug use

	Yes	No
Do you currently drink alcohol?	☐	☐

↓ (if yes) How many units per week? ☐☐ units per week

	Yes	No
Do you currently smoke?	☐	☐

If yes:

How many cigarettes? ☐☐ per day **or** ☐☐ per week

How many vaping sessions? ☐☐ per day **or** ☐☐ per week
One session is classified as 5 or more inhalations

If no:

Have you recently stopped? ☐ Yes ☐ No

If yes, how recently did you stop? ☐ < 1 month ☐ 1-6 months ☐ > 6 months

	Yes	No
Do you take any other recreational drugs?	☐	☐

If yes, please complete table:

Type	Frequency of use (tick one option)
	☐ Daily ☐ 2-3 times per week ☐ Weekly ☐ Bi-weekly ☐ Monthly ☐ Every 2-3 months ☐ Every 6 months
	☐ Daily ☐ 2-3 times per week ☐ Weekly ☐ Bi-weekly ☐ Monthly ☐ Every 2-3 months ☐ Every 6 months
	☐ Daily ☐ 2-3 times per week ☐ Weekly ☐ Bi-weekly ☐ Monthly ☐ Every 2-3 months ☐ Every 6 months
	☐ Daily ☐ 2-3 times per week ☐ Weekly ☐ Bi-weekly ☐ Monthly ☐ Every 2-3 months ☐ Every 6 months
	☐ Daily ☐ 2-3 times per week ☐ Weekly ☐ Bi-weekly ☐ Monthly ☐ Every 2-3 months ☐ Every 6 months
	☐ Daily ☐ 2-3 times per week ☐ Weekly ☐ Bi-weekly ☐ Monthly ☐ Every 2-3 months ☐ Every 6 months

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Diet and supplements

How many days a week do you eat the following foods:

Tick one box per food type

	Number of days per week							
	0	1	2	3	4	5	6	7
Red meat	☐	☐	☐	☐	☐	☐	☐	☐
White meat	☐	☐	☐	☐	☐	☐	☐	☐
Fish	☐	☐	☐	☐	☐	☐	☐	☐
Eggs	☐	☐	☐	☐	☐	☐	☐	☐
Fresh fruit	☐	☐	☐	☐	☐	☐	☐	☐
Fresh vegetables	☐	☐	☐	☐	☐	☐	☐	☐
Dairy products	☐	☐	☐	☐	☐	☐	☐	☐
Soya products	☐	☐	☐	☐	☐	☐	☐	☐
Chocolate	☐	☐	☐	☐	☐	☐	☐	☐
Nuts (almonds/walnuts)	☐	☐	☐	☐	☐	☐	☐	☐

Do you consume sugar substitutes daily or most days of the week? ☐ Yes ☐ No

How many cups of coffee* do you drink in a typical day? ☐ cups of coffee/day

How many cups of tea* do you drink in a typical day? ☐ cups of tea/day

How many cans (or equivalent) of soft drink do you consume per day (e.g. energy drinks, cola)? ☐ cans/day

Do you currently take any vitamins or supplements? ☐ Yes ☐ No

If yes, please provide details:

	Name of product	**Frequency (times/week)**	**How long have you been taking it? (weeks)**
1			
2			
3			
4			

* Do not count decaffeinated drinks

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Diet and supplements

If you are not taking vitamins or minerals currently but have taken them in the last four months please complete this table.

	Name of product	Frequency (times/week)	Duration (weeks)
1			
2			
3			
4			

Are you currently taking any protein shakes or protein bars? ☐ Yes ☐ No

If yes, please provide details:

	Name of product	Frequency (times/week)	Duration (weeks)
1			
2			
3			
4			

Exercise

Do you follow a regular routine of physical exercise? ☐ Yes ☐ No

How many days a week do you exercise?

Tick one option

- 0 ☐
- 1-2 ☐
- 3-4 ☐
- 5-6 ☐
- 7 ☐

If you exercise, how many hours a day do you exercise?

Tick one option

- < 30 min ☐
- 30 min - 1 hr ☐
- > 1 hr - 1.5 hrs ☐
- > 1.5 hrs - 2 hrs ☐
- > 2 hrs - 2.5 hrs ☐
- > 2.5 hrs ☐

On average how many hours do you spend sitting on a chair per day?

Sofa or armchair ☐ hours/day Work chair ☐ hours/day

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Previous illnesses or medical problems

Have you had any serious illnesses or medical problems? Yes ☐ No ☐

If yes, tick all applicable:

Diabetes	☐	Rheumatism or painful joints	☐
Thyroid problems	☐	Skin rashes or other skin disorders	☐
Cancer	☐	Irritable Bowel Syndrome	☐
Heart problems	☐	Coeliac disease	☐
Liver problems	☐	Crohn's disease	☐
Migraines	☐	Autoimmune disease	☐
Epilepsy	☐	Other inflammatory disorder	☐
Depression	☐	Thrombosis (clots in legs or chest)	☐
High blood pressure	☐	Candida (thrush)	☐
Lupus (SLE)	☐	Bacterial vaginosis	☐
Abnormal vaginal discharge	☐		

Other illnesses ☐ Please state: _____

If you have ticked any of the boxes above, please provide further details below:

Current medications and allergies

Please provide details on any allergies you have and medication you are currently taking below:

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Family medical problems

Has your mother, father, siblings or maternal aunt(s) had any medical complications? Yes ☐ No ☐

If yes, tick all applicable:

- Miscarriage ☐
- Recurrent (3 or more) miscarriages ☐
  - If yes: Number of 1st trimester losses (<12 weeks) ☐☐
  - Number of 2nd trimester losses (>12 weeks) ☐☐ ☐ I don't know
- Obstetric complications (such as pre-eclampsia and growth restriction) ☐
- Genetic or developmental problems ☐
- Heart problems under the age of 50 ☐
- Stroke under the age of 50 ☐
- Still birth ☐
- Pre-term birth ☐
- Infertility ☐
- High blood pressure ☐
- Diabetes ☐
- Blood clots (thrombosis) ☐
- Depression ☐
- Other ☐

Please state: _____

If you have ticked any of the boxes above, please provide further details below:

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Tests and investigations

Please give details of any tests or investigations you've had as a part of your miscarriage treatment.

Test/investigations	Date of test	Result	Which hospital or clinic did you have the test at?
FSH			
LH			
Oestradiol			
Haemoglobin			
Platelets			
Rubella immunity			
Thrombophilia screening			
Thyroid antibodies			
Thyroid function test			
Sexually transmitted disease			
Ultrasound			

If you've had any other tests, please state below:

Test/investigation	Date of test	Result	Which hospital or clinic did you have the test at?

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Treatments

Please give details of any treatments you've previously received or are currently receiving as a part of your miscarriage management.

Please also include any medications that you've bought yourself.

Treatment (please include medicines and operations)	Dose	Date from*	Date to	Tick if ongoing	Additional clinician's notes
				☐	
				☐	
				☐	
				☐	
				☐	
				☐	
				☐	
				☐	

* If an operation, please give the date of operation

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Examination

This section should be completed in conjunction with a member of the research team who attends to you in the clinic

Weight: ☐☐☐ kg Height: ☐☐☐ cm BMI: ☐☐.☐

Blood pressure: ☐☐☐ / ☐☐☐ mmHg
Systolic Diastolic

Examination findings (if appropriate)

For Tommy's research office use only if patient is consented and registered to take part in Tommy's research

Date of consent: d d - m m m - y y y y

Patient ID: ☐ ☐ ☐ ☐ - M A T

Recruiting site:

Date entered onto database: __/___/____ Entered Date checked: __/___/____ Checked by:

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Ethnicity codes

WHITE		**Category includes**
A	White British	English, Scottish, Welsh, Cornish
B	White Irish	
C	Any other white background	Former USSR, Baltic States, Former Yugoslavia, Other European, White South African, American, Australian, New Zealander, Mixed White
CF	Greek	
CG	Greek Cypriot	
CH	Turkish	
CI	Mediterranean	Italian, Portuguese and Spanish
CJ	Turkish Cypriot	
CN	Jewish	
CY	Other White European	
MIXED		
D	White & Black Caribbean	
E	White & Black African	
F	White & Asian	
G	Any other mixed background	
ASIAN OR ASIAN BRITISH		
H	Indian	British Indian, Punjabi
J	Pakistani	British Pakistani, Kashmiri
K	Bangladeshi	British Bangladeshi
L	Any other Asian background	British Asian, East African Asian, Sri Lankan, Tamil, Sinhalese, Caribbean Asian, Nepalese, Mixed Asian
BLACK OR BLACK BRITISH		
M	Black Caribbean	Caribbean, West Indian Islands (and also Guyana) apart from Puerto Rican, Dominican and Cuban, which are
N	Black African	Nigerian, Kenyan, Black South African, Other Black African Countries
P	Other Black background	Black American, Mixed Black
PA	Somali	
PE	Black British	
OTHER ETHNIC GROUPS		
R	Chinese	inc. Hong Kong
S	Any other ethnicity	Japanese, Filipino, Malaysian, Aborigine, Afghani, Burmese, Fijian, Inuit, Maori, Native American Indian, Thai, Tongan, Samoan, Iranian, Israeli, Kurdish, Latin American (inc. Cuban, Puerto Rican, Dominican, Hispanic), Moroccan, Multi Ethnic Islands (inc. Seychellois, Maldivian, St. Helena), Other Middle Eastern (inc. Iraqi, Lebanese, Yemeni), Other North African, South American (inc. Central America).
SA	Africa—colour not defined	
SC	Arab	
SD	Vietnamese	
Z	Not stated	

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Religion codes

A	Christian (all denominations)
B	Buddhist
C	Hindu
D	Jewish
E	Muslim
F	Sikh
G	Agnostic
H	Atheist
I	I'd rather not say
J	Other (please specify)

Marital status codes

A	Single
B	Married
C	Separated
D	Divorced
E	Widowed

Education codes

A	No formal qualifications
B	1-4 GCSEs (A*-C) or equivalent
C	5+ GCSEs (A*-C) or equivalent
D	Apprenticeship
E	2+ A-levels or equivalent
F	Degree or above
G	Other (please specify)

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