



# Medical Assessment Form - Confidential

Name: ..... Date of Birth: .....

Address: .....  
.....

Type of home

Flat	
Maisonette	
House	
Bungalow	

If you live in a flat, what level is it on? .....

Please tell us what health problem(s) you have (or anyone else in your household)  
.....  
.....  
.....

Would you prefer to stay in your home if you could? 

Yes	No
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The questions below give you the chance to tell us how your housing affects your health.

## Getting Around Your Home

Do you have any difficulty walking? 

Yes	No	Some
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If yes, do you use any of the following to help you get around?  

Walking stick	
Walking frame	
Wheelchair	

If you use a wheelchair, do you use it indoors or outdoors? 

Both	Outdoors
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Do you have any difficulty with stairs inside or outside your home? 

Yes	No
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Please tell us what problems you have with stairs:  
.....  
.....  
.....

Please indicate how many stairs there are in your home.

Inside	
Outside	

Are there handrails on the stairs?

Yes	No
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Are they on one or both sides?

One	
Both	

How many stairs would you be able to manage easily?

.....

Do you have, or need, any equipment to help you with the stairs?  
(please describe)

Yes	No
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.....  
.....

**Bathroom**

What facilities does your bathroom have?

Bath	
Shower over the bath	
Separate shower unit	
Wet floor area	

Do you have any difficulty using the bath, shower or toilet?  
If yes, please tell us about it

Yes	No
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.....  
.....

Do you have to go upstairs to the

Toilet?	
Bathroom?	
Bedroom?	

**Heating**

What sort of heating do you have?

.....

What sort of heating would you prefer?

.....

If you have any other comments about heating or ventilation in your home please note them here:

.....

## Dampness

Does your home have any dampness?

Yes	No
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If this affects your health please tell us about it:

.....

.....

## Bedroom

Does your illness or disability mean you need an extra bedroom?  
If yes, please tell us why:

Yes	No
-----	----

.....

.....

## Shopping and Transport

Do you go to the shops alone?

Yes	No
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How do you get there?

Walk	
Bus	
Car	
Taxi	

Do you have difficulty getting to the shops and other places?  
Please tell us what these difficulties are:

Yes	No	Some
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.....

.....

## Other Health Problems

If your health problem is not covered by the questions above, please tell us how your housing situation affects your illness or disability, and how you feel a move would help:

.....

.....

.....

.....

## Hospital

Do you regularly attend a hospital or clinic?

Yes	No
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If so, which hospital/clinic? .....

What is your consultant's name? .....

## Family Doctor

What is your doctor's name? .....

Address?  
.....  
.....

If you get regular support from anyone else, such as a district nurse or occupational therapist, please give their name and address:  
.....  
.....

## Getting Further Information

Do we have your permission to contact any of the above people should we need more information about your health?

Yes	No
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Signature: .....

Date: .....