

**Nutrition in Sheffield**

***Health Questionnaire***

**Please fill in all questions as carefully and as accurately as you can. If there is not enough space on the paper, please continue on a separate sheet.**

|  |  |
| --- | --- |
| Full name: |  |
| Address: |  |
| Tel. no: |  |
| Mobile no: |  |
| Email address: |  |
| Date of birth: |  |
| Height: |  |
| Weight: |  |
| Occupation: |  |
| GP’s details (We will not contact your GP without your permission) |  |

**General Health Questions**

|  |  |
| --- | --- |
| What is your main health concern(s) / reason(s) for consultation? |  |
| Are you aware of any triggers for this condition / these conditions? If so, please list. |  |
| How long have you had these health concern(s)? |  |
| Please list any health conditions, operations or accidents that you have had in the past (eg. Childhood asthma, gall bladder removal etc) |  |
| What treatment was given for these health conditions and how effective was it? |  |
| Please list any medical or functional test results that you have available, or attach them to this form. |  |
| Please list any medications that you are currently taking. Please note what they are for, the name and the dosage. |  |
| Please list any supplements that you are taking. Please note why you are taking them, who prescribed them, the brand and the dosage. |  |
| ***Please underline if any of the following apply to you:***  **Pain**: any pain which is persistent or severe in head, abdomen, chest, eye or temple, on passing urine, or any other  **Bleeding**: blood in sputum, vomit, urine, or stool  **Changes in**: appetite, bowel habit, passing of urine, skin, personality / behaviour, body / face shape, vision, breathing, swallowing | |
| Are there any particular illnesses or conditions in your blood relatives? (e.g. heart disease, cancer etc.) If so please state which disease(s) and which relative(s). | |

**General dietary analysis**

*Please note this is in addition to your five day food diary to provide some more general information that may or may not be illustrated in the five days you recorded.*

|  |  |
| --- | --- |
| Do you have any dietary restrictions? E.g. vegetarian, vegan, don’t eat meat, cultural or religious preferences |  |
| Approximately how often per week do you eat biscuits or cakes? |  |
| Approximately how often per day or week do you eat dairy products such as milk, cheese, yoghurt, butter etc? |  |
| Approximately how often per day or week do you eat wheat products such as bread, pasta, cakes and biscuits? |  |
| On average, how many portions of fresh fruit do you eat each day? |  |
| On average, how many portions of vegetables or salad do you eat each day? |  |
| On average, how many portions of oily fish would you eat in a week? |  |
| On average, how many portions of red meat do you eat in a week? |  |
| On average, how many cups of caffeinated tea or coffee do you drink each day? |  |
| On average, how often do you eat ready meals or take-aways per week? |  |
| On average, how often do you eat obviously processed foods such as processed meats or processed cheeses? |  |
| Do you add salt to your cooking? |  |
| Do you add salt at the table? |  |
| Approximately how many glasses of water do you drink per day? |  |
| What kind of oil do you use to sauté or fry vegetables? |  |
| What kind of oil do you use in salad dressings? |  |
| Approximately how often do you deep fry or eat deep fried foods? |  |
| Approximately how often do you eat barbecued foods? |  |
| Approximately how often do you eat smoked foods (eg. Smoked fish, smoked meat)? |  |
| Do you generally boil or steam vegetables (other than potatoes)? |  |

**Cardiovascular health**

|  |  |
| --- | --- |
| Do you have a personal or a family history of high blood pressure? (If a personal history, please give approx. measurement if you know it) |  |
| Do you have a personal or a family history of high cholesterol? |  |
| Do you have a diagnosed cardiovascular disease? |  |
| Do you ever experience palpitations? If so, when? |  |
| Would you say that your lifestyle was sedentary; moderate or very active? |  |
| Do you ever take planned exercise? If so, what kind and how often? |  |
| Do you get easily out of breath? If so, on what occasions? |  |
| Do you ever suffer from chest pains? If so, when? |  |
| Are you prone to putting weight on around your middle rather than your hips? |  |
| How many units of alcohol do you drink per week? |  |
| What kind of alcohol do you generally drink? |  |
| Do you smoke? If so, how many per day or week? |  |

**Glucose Tolerance**

|  |  |
| --- | --- |
| Do you feel a need to eat frequently during the day? (e.g. every couple of hours or so) |  |
| *If you go for more than 3 hours without a meal, do you feel:* |  |
| Irritable |  |
| Unable to concentrate |  |
| Have a headache |  |
| Shaky |  |
| Weak |  |
| Tired |  |
| Anxious or nervous |  |
| Crave caffeine or a cigarette |  |
| Crave sugary food |  |
| *Very often, do you experience:* |  |
| Excessive urination |  |
| Excessive thirst |  |
| Breath smells sweet |  |
| Unintended weight loss |  |
| Unintended excessive weight gain |  |

**Adrenal stress and Thyroid function**

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| --- | --- |
| Do you feel that you sweat excessively? I.e. significantly more than other people in the same situation |  |
| Do you feel you have more than usual difficulty building muscles? |  |
| Do you have difficulty falling asleep? |  |
| Do you have low blood pressure? If so, do you know what it is? |  |
| Would you say that you have poor stress tolerance? (i.e. you find it more difficult than usual to handle stressful situations) |  |
| Are you prone to food allergies or sensitivities that you know of? If so, which? |  |
| Do you have cold hands or cold feet? |  |
| Do you crave salt or salty foods? |  |
| Does exercise cause more fatigue than you would expect? |  |
| Do you feel light headed or dizzy when you stand up? |  |
| Do you have fatigue or lethargy that is not relieved by sleep? |  |
| Do you feel it is always hard to get up in the morning, even after a good night’s sleep? |  |
| Do you feel run down or overwhelmed? |  |
| Do you feel the need to sleep more than usual for no apparent reason? |  |
| Do you find it difficult to lose weight even when you are consciously eating less and exercising more? |  |
| Do you feel the cold more than other people? |  |
| Do you have poor digestion and / or a tendency to constipation? |  |
| Do you tend to feel sluggish or lethargic? |  |
| Do you feel that your brain is ‘foggy’ or on a ‘go slow’? |  |
| Do you find it hard to remember things or concentrate? |  |
| Do you feel that you are depressed for no real reason? |  |
| Do you have less interest in sex than you feel would be usual for you? |  |
| Do you have menstrual irregularities? If so, please briefly describe. |  |
| Have you ever had a miscarriage? |  |
| Have you ever been diagnosed as infertile? |  |
| Have you noticed that your hair has become coarser, thinner or both? |  |
| Have you noticed that the outer third of your eyebrows is losing hair? |  |

**Female Health**

|  |  |
| --- | --- |
| Have you ever had fertility problems? If so, please briefly describe |  |
| Do you generally have periods that are heavy and / or prolonged or painful? If so, please briefly describe. |  |
| Do you suffer from PMS? If so, please briefly describe |  |
| What kind of contraception do you use? |  |
| Are you trying to become pregnant? |  |
| Are you pregnant? If so, how many weeks? |  |
| Are you breastfeeding? If so, how old is your baby? |  |
| Are you menopausal / post menopausal? |  |
| Do you take HRT and if so for how long have you taken it? |  |

**Immune Health and Toxic Exposure**

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| --- | --- |
| Do you eat organic foods? If so, how often? |  |
| Do you filter your drinking water? |  |
| Do you use chemicals in your job? |  |
| How many mercury fillings do you have? |  |
| Do you use recreational drugs? If so, which ones and how often? |  |
| Are you prone to frequent colds and infections? |  |
| Are you prone to cold sores? |  |
| Are you prone to thrush and / or cystitis? |  |

**Allergies and sensitivities**

|  |  |
| --- | --- |
| Please list any known allergies or sensitivities. |  |
| Are there any foods or drinks that you really crave and feel ‘addicted’ to? |  |
| *Please tick if you suffer from any of the following:* |  |
| Asthma |  |
| Hives |  |
| Eczema |  |
| Hay fever |  |
| Migraines |  |
| Facial puffiness |  |
| Unexplained itching or watery eyes |  |
| Dark circles under the eyes |  |
| Sinusitis |  |
| Excessive sneezing |  |
| Constant sore throat or runny nose or excess mucus production |  |
| Joint pain or stiffness |  |
| Unexplained muscle aches and pains |  |
| Itchy skin or skin rashes |  |
| Fluid retention unrelated to PMS |  |
| Rapid weight fluctuations |  |
| Fatigue after meals or certain foods (if so, please note which) |  |
| Binge eating |  |
| Unexplained depression |  |
| Colon cramps |  |
| IBS (if so, please briefly describe) |  |
| Crohn’s disease or ulcerative colitis |  |

**Digestive Health**

|  |  |
| --- | --- |
| Are you prone to gastritis or gastric ulcers? |  |
| How often, if ever, do you have heartburn? |  |
| Do you ever have unexplained stomach pains related to digestion? |  |
| Do you ever have a sour taste in your mouth? |  |
| Do you have abdominal bloating or excessive flatulence? |  |
| Do you ever see undigested food in your stools? |  |
| Do you ever have stools that are hard and difficult to pass or constipation? |  |
| Do you feel nauseous after taking supplements? |  |
| Do you eat in a real hurry? |  |
| Do you have weak, peeling, split or ridged nails? |  |
| Do you feel bloated after eating fruit? |  |
| Are you intolerant to alcohol? (i.e. small amounts make you feel ill) |  |
| Do you have a yellowish cast to your skin or eyes? |  |
| Do you have a family or personal history of liver or gall bladder disease? |  |
| Do you feel ill or have pain or sickness after eating fatty foods? |  |
| Are you stools very light or clay coloured? |  |
| How often have you taken antibiotics in your life? |  |
| When was the last time you took antibiotics? |  |
| Do you have any itching around the rectum? |  |
| Do you have any history of parasitic infection? If so, please briefly describe. |  |
| How often do you take NSAIDs (e.g. nurofen) |  |
| Do you have difficulty gaining weight? |  |

**Vitamins and minerals**

*Please tick or circle or highlight anything that applies to you. Please note everything that applies, however often it comes up.*

|  |  |  |  |
| --- | --- | --- | --- |
| C  Prone to colds  Prone to infections  Slow wound healing  Broken capillaries  Varicose veins  Easy bruising  Bleeding or swollen gums  Nose bleeds  Anaemia  Smoker  Stressful lifestyle  Spend lots of time in traffic | A  Poor night vision  Eye lesions or ulcers  Ulcers – gastric or mouth  Acne  Eczema or psoriasis  Asthma  Sinusitis  Prone to colds  Prone to infections | D  Depression  Osteoporosis  Joint pain or stiffness  Bony deformities  Arthritis  Tooth decay  Psoriasis  Poor immunity  Age over 60 | E  Infertility  Miscarriages  Anaemia / skin pallor  Cataracts  Heart disease  Shortness of breath  Accelerated ageing  Age spots  Low sex drive |
| B1  Numbness in legs  Burning feet or hands  Fatigue  Pins and needles  Poor concentration  Poor memory  Headaches  Indigestion / stomach pains  Sleep disturbance | B2  Red, burning or gritty eyes  Sensitive to bright lights  Seborrhoeic dermatitis  Blurred vision  Dry cracking or peeling lips  Mouth cracks (corners) | B3  Dermatitis  Diarrhoea  Dementia or severe memory loss  Depression  Irritability  Headaches or migraines  High cholesterol  Blood sugar imbalances  Raynaud’s disease | B5  Poor stress tolerance  Stressful lifestyle  Rheumatoid arthritis  Apathy  Depression  Dizziness upon standing  Fatigue  Numbness in the feet  Allergies / sensitivities |
| B6  Poor dream recall  Mood swings  Depression  PMS  Water retention  Heart disease  Carpal tunnel syndrome  Eczema  Seborrhoeic dermatitis  Asthma  Allergies | B12  Anaemia / skin pallor  Fatigue  Weakness  Sciatica  Smooth, sore tongue  Irritability or moodiness  Tingling in hands / feet  Poor memory  Age over 60 | F.A  Anaemia / skin pallor  Fatigue  Shortness of breath  Preconceptual  Miscarriages  Pregnant  Cardiovascular disease  Regular alcohol use  Heavy blood loss | Biotin  Dry greyish skin  Seborrhoeic dermatitis  Scaly facial rash  Poor hair condition  Excessive hair loss  Fungal infections  Candida  Seizures  Hearing problems |
| Ca  Osteoporosis  Joint pains / arthritis  Muscle cramps  Brittle nails  Tooth decay  Difficulty falling asleep  Anxiety, nervousness  High blood pressure  Age over 60 | Mg  Irregular heart beat  High blood pressure  Low blood sugar  Muscle cramps or spasms  Poor sleep patterns  Migraines  Asthma  PMS  Constipation | K  Irregular / rapid heartbeat  High blood pressure  Muscle cramps or spasms  Fatigue  Slow reflexes  Constipation  Water retention  Dry skin | Fe  Anaemia  Skin pallor  Fatigue or listlessness  Excessive hair loss  Breathlessness  Brittle hair or nails  Heavy blood loss  Sore tongue  Cracks on edge of mouth |
| Zn  White spots on more than two fingernails  Stretch marks  Poor sense of taste / smell  Weight loss  Slow wound healing  Susceptibility to infections  Infertility  Depression  Slow hair and nail growth  Acne or greasy skin  Hair loss | Cu  Anaemia  Skin pallor  Bleeding gums  Easy bruising  Skin sores  Hair / skin depigmentation  Depression  Prone to infections  Cardiovascular disease | Mn  Arthritis  Disc or cartilage problems  Sore knees  Reduced fertility  Blood sugar imbalances  Hearing loss  Tinnitus  Poor sense of balance  artherosclerosis | Cr  Low blood sugar  Cravings for sweets  Cravings for stimulants  Drowsiness during day  Need for frequent meals  Lack of energy  Poor concentration  Anxiety or irritability  High cholesterol |
| Se  Family or personal history of cancer  Cardiovascular disease  High blood pressure  High cholesterol  Mercury dental fillings  Chemical hypersensitivity  Cataracts  Age spots | I  Goiter  Fatigue  Weakness  Oestrogen based cancer  Weight gain  Depression  Hypothyroidism  Fibrocystic breasts  Do not eat any seafood | B  Osteoporosis  Arthritis  postmenopausal | EFA  Dry skin or eyes  Dry mucous membranes  Brittle or cracked nails  Eczema  Psoriasis  Excessive thirst  Inflammation  Allergic tendencies  Hay fever  Asthma  High blood pressure  High cholesterol  Decreased fertility  PMS  Breast pain  Depression |

**Please note any other information that may be relevant to your health or that you wish me to take into account.**

**Declaration**

***I confirm that this information is correct to the best of my knowledge and that I am not withholding any information that may be important.***

***Date Signed***