

**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**

|  |  |
| --- | --- |
| 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**

|  |  |
| --- | --- |
| 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.*

|  |  |  |  |
| --- | --- | --- | --- |
| CProne to coldsProne to infectionsSlow wound healingBroken capillariesVaricose veinsEasy bruisingBleeding or swollen gumsNose bleedsAnaemiaSmokerStressful lifestyleSpend lots of time in traffic | APoor night visionEye lesions or ulcersUlcers – gastric or mouthAcneEczema or psoriasisAsthmaSinusitisProne to coldsProne to infections | DDepressionOsteoporosisJoint pain or stiffnessBony deformitiesArthritisTooth decayPsoriasisPoor immunityAge over 60 | EInfertilityMiscarriagesAnaemia / skin pallorCataractsHeart diseaseShortness of breathAccelerated ageingAge spotsLow sex drive |
| B1Numbness in legsBurning feet or handsFatiguePins and needlesPoor concentrationPoor memoryHeadachesIndigestion / stomach painsSleep disturbance | B2Red, burning or gritty eyesSensitive to bright lightsSeborrhoeic dermatitisBlurred visionDry cracking or peeling lipsMouth cracks (corners) | B3DermatitisDiarrhoeaDementia or severe memory lossDepressionIrritabilityHeadaches or migrainesHigh cholesterolBlood sugar imbalancesRaynaud’s disease | B5Poor stress toleranceStressful lifestyleRheumatoid arthritisApathyDepressionDizziness upon standingFatigueNumbness in the feetAllergies / sensitivities |
| B6Poor dream recallMood swingsDepressionPMSWater retentionHeart diseaseCarpal tunnel syndromeEczemaSeborrhoeic dermatitisAsthmaAllergies | B12Anaemia / skin pallorFatigueWeaknessSciaticaSmooth, sore tongueIrritability or moodinessTingling in hands / feetPoor memoryAge over 60 | F.AAnaemia / skin pallorFatigueShortness of breathPreconceptualMiscarriagesPregnantCardiovascular diseaseRegular alcohol useHeavy blood loss | BiotinDry greyish skinSeborrhoeic dermatitisScaly facial rashPoor hair conditionExcessive hair lossFungal infectionsCandidaSeizuresHearing problems |
| CaOsteoporosisJoint pains / arthritisMuscle crampsBrittle nailsTooth decayDifficulty falling asleepAnxiety, nervousnessHigh blood pressureAge over 60 | MgIrregular heart beatHigh blood pressureLow blood sugarMuscle cramps or spasmsPoor sleep patternsMigrainesAsthmaPMSConstipation | KIrregular / rapid heartbeatHigh blood pressureMuscle cramps or spasmsFatigueSlow reflexesConstipationWater retentionDry skin | FeAnaemiaSkin pallorFatigue or listlessnessExcessive hair lossBreathlessnessBrittle hair or nailsHeavy blood lossSore tongueCracks on edge of mouth |
| ZnWhite spots on more than two fingernailsStretch marksPoor sense of taste / smellWeight lossSlow wound healingSusceptibility to infectionsInfertilityDepressionSlow hair and nail growthAcne or greasy skinHair loss | CuAnaemiaSkin pallorBleeding gumsEasy bruisingSkin soresHair / skin depigmentationDepressionProne to infectionsCardiovascular disease | MnArthritisDisc or cartilage problemsSore kneesReduced fertilityBlood sugar imbalancesHearing lossTinnitusPoor sense of balanceartherosclerosis | CrLow blood sugarCravings for sweetsCravings for stimulantsDrowsiness during dayNeed for frequent mealsLack of energyPoor concentrationAnxiety or irritabilityHigh cholesterol |
| SeFamily or personal history of cancerCardiovascular diseaseHigh blood pressureHigh cholesterolMercury dental fillingsChemical hypersensitivityCataractsAge spots | IGoiterFatigueWeaknessOestrogen based cancerWeight gainDepressionHypothyroidismFibrocystic breastsDo not eat any seafood | BOsteoporosisArthritispostmenopausal | EFADry skin or eyesDry mucous membranesBrittle or cracked nailsEczemaPsoriasisExcessive thirstInflammationAllergic tendenciesHay feverAsthmaHigh blood pressureHigh cholesterolDecreased fertilityPMSBreast painDepression |

**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***