Please find herewith your copy of the Health Questionnaire.

Please print and complete the questionnaire honestly and return it to

"Confidential Questionnaire".
Cytoplan Ltd,
Unit 8, Hanley Workshops
Hanley Swan
Worcestershire.
WR8 ODX

We will respond to your questionnaire personally and directly to you.
Let us reassure you that your details will not be viewed by anyone other than our nutritionist.

Yours sincerely
Cytoplan Ltd

Health Questionnaire

Private and confidential

Mr / Mrs /Miss /Ms **First Name**……………………………….. **Last Name**……………………………….. **Address:** Postcode**:** **Email:** **Tel** (home)**:** **Tel** (work)**:** **Mobile**	D.O.B……………………………………. Marital status……………………………… Children ………..ages……………………. Current weight……………………………. Current height……………………………. **Job Description:** Full time/ Part time hours

Sections **a** and **b** are voluntary information.

a)General Practitioner details

Are they interested in nutrition? yes/ no /don't know

Name ……………………………………………..

Address………………………………………………………………………………………

……………………………………………………………………………………………..

Telephone number………………………………..

b)Specialist or Practitioner details (if appropriate)

Name ………………………………….

Please indicate if a Medical Specialist or Practitioner Medical / Non medical

Their subject specialty……………………………………………………………………………..

E-mail Address………………………………………………………

Address……………………………………………………………….

Telephone number……………………………………………………

If you would like us to write on your behalf to your General Practitioner /or specialist about our recommendations to you then please sign and date below.

signature………………………………………………………date ……………………

We will not contact your GP or Practitioner without your written consent.

Please state briefly your reasons for completing this questionnaire today. If you have specific health concerns you are wishing to address it is essential you detail these here. ……………………………………………………………………………………

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- ………………………………………………………………………………………
- ………………………………………………………………………………………
- ……………………………………………………………………………………..
- ……………………………………………………………………………………..

<u>Section A Your Health History</u> Have you now or in the past had any of the following ?
Tick if the answer is **YES** and provide details below.

□ **Allergies**	□ **Stomach Ulcers**
□ **Asthma or chest conditions**	□ **Bowel problems**
□ **Eczema**	□ **Menstrual / Menopausal problems**
□ **Skin conditions**	□ **Arthritis or Rheumatism**
□ **Thyroid problems**	□ **Ear, Eye, Nose or Throat problems**
□ **Diabetes**	□ **Epilepsy/fits or nervous condition**
□ **Heart disease**	□ **Drug or Alcohol dependence**
□ **Hypertension**	□ **Anxiety or Depression**
□ **Kidney trouble**	□ **Sleep problems**
□ **Bladder trouble**	□**Cancer**
□ **Osteoporosis**	□

Please give details of the above including onset, and if applicable cessation dates, also indicating those conditions currently receiving medical treatment. For those conditions which are still current see page 8 of the questionnaire.

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<u>Surgical procedures;</u>

Please provide details as to nature of surgery and dates.

………………………………………………………………………………………
………………………………………………………………………………………

<u>Medicines and Supplements;</u>

Please give details of any medicines you are taking now (Dose and Frequency)

……………………………………………………………………………………….

……………………………………………………………………………………….

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To help jog your memory:

Antacids . Antibiotics (especially repeated courses). Anticoagulants. Antidepressants. Blood Pressure medication, GTN spray Heart medication. Hormonal Contraceptives. HRT. Inhalers. Insulin or diabetic tablets. Sedatives. Sleeping pills. Thyroid medication. Tranquillisers. This may be important due to possible drug-nutrient or nutrient-nutrient interactions.

Please note in our opinion there is a higher need for good nutrition if you are taking pharmaceutical medication therefore these details are helpful to give the best advice.

Section B: Nutrition and Diet

Please complete the attached Food Diary separately.

Nutrition and Diet:
please tick alongside which of these most relates to your present diet:

□ Mixed food diet (animal and vegetable sources)
□ Vegetarian
□ Lacto vegetarian
□ Lacto ovo vegetarian
□ Salt restriction
□ Fat restriction
□ Starch/carbohydrate restriction
□ Total calorie restriction
□ Other (please identify)
Specific Food Restriction
…..Dairy …..eggs …..soy ….corn …..wheat ….all gluten
…..Other

Food Frequency:
Servings per day:
Fruits……. Please list fruits consumed by name……………………………………………..
……………………………………………………………………………………………...
Vegetables…….. Please list vegetable varieties consumed ………………………………….
…………………………………………………………………………………………………
……………………………………………………………………………………………......
Grains (unprocessed)…………. Please list grains consumed………………………………..
……………………………………………………………………………………………..
Beans, peas, legumes, pulses……
Dairy/eggs…….. please list products consumed in this category……………………………..
Meat/poultry/fish…………please list products consumed in this category……………………
……………………………………………………………………….

Eating Habits (please tick any of the following which apply)
□ skip breakfast
□ 2 meals/day
□ 1 meal/day
□ graze (small frequent meals)
□ food rotation
□ eat constantly whether or not hungry
□ generally eat on the run
□ add salt to food

Current supplements
Please list all supplements that you take or have taken in the last year regularly, the quantity and frequency of taking:

…………………………………………………………………………………………………
…………………………………………………………………………………………………
…………………………………………………………………………………………………

Non-prescription medications used:
Please list any medications and or herbal products taken on a regular or frequent basis.
…………………………………………………………………………………………………
…………………………………………………………………………………………………
…………………………………………………………………………………………………..
Examples: laxatives, indigestion medication, pain relief, nasal decongestants, sleep aids, anti diarrhoea, herbal products for PMS, menopause etc.

Do you have any concerns for yourself with regard medical conditions within your family history. E.g. Arthritis, Diabetes, Heart disease, Osteoporosis…………………………………………
………
………
………
………

Health Habits: Please indicate the quantity per day)

…..tobacco:
…..cigarettes …..cigars

Alcohol:
Wine (red or white) glasses per day…….. total per week……………..
please indicate glass size small/medium/large.
Spirits(single measures) per day…………total per week…………..
Beer , Lager, Cider (pints) per day……… total per week…………

Caffeine:
Coffee 6oz cups per day…..
Tea 6oz cups per day…..
Cola cans per day……

Soda/diet drinks/ etc cans per day……..
Energy/glucose drinks per day………
Water glasses (250ml) number per day …………….. or litres per day………

Exercise
Number days per week : 1-2 □ 2-3 □ 4-5 □ 6-7 □
Duration per session: less than 30 minutes □ 30-45 mins □ 45 mins or more □

Please detail types of exercise undertaken on a regular basis:
…………………………………………………………………………………………………
…………………………………………………………………………………………………
…………………………………………………………………………………………………
………………………………………………………………………………………………..

Section C: Well being

The purpose of this section of the questionnaire is to measure your perception of your well being.

General Well being
Thinking about your well being over all, how do you feel today.
(Please circle the relevant number that fits you today)

9.Excellent
8. Very good
7. Good
6. Fairly good
5. Average
4. Below average
3. Not good
2. Bad
1. Very bad

Physical Well being
Thinking about your physical well being over all, how do you feel today.
(Please circle the relevant number that fits you today)

9.Excellent
8. Very good
7. Good
6. Fairly good
5. Average
4. Below average
3. Not good
2. Bad
1. Very bad

Emotional Well being
Thinking about your emotional well being over all, how do you feel today.
(Please circle the relevant number that fits you today)

9.Excellent
8. Very good
7. Good
6. Fairly good
5. Average
4. Below average
3. Not good
2. Bad
1. Very bad

Section C 2

Symptoms This section covers symptoms you may be experiencing currently, physically or emotionally
From your health concerns detailed on page 1, please prioritise those you would most like assistance with, give each a score by circling the most relevant one for you, you may add the word you feel describes this best.

Symptom 1

....
9. Not a problem
8.
7.
6.
5.
4.
3.
2.
1. Unbearable

Symptom 2

....
9. Not a problem
8.
7.
6.
5.
4.
3.
2.
1. Unbearable

Symptom 3

....
9. Not a problem
8.
7.
6.
5.
4.
3.
2.
1. Unbearable

Symptom 4

....
9. Not a problem
8.
7.
6.
5.
4.
3.
2.
1. Unbearable

Section D: Food Diary. Please write down all the foods and drinks you consume over a **three** day period, including **one** weekend day. It is **essential** that you complete this as **accurately** and **honestly** as possible and **include portion sizes**.

Day 1

Breakfast ……………………………………
……………………………………………
……………………………………………
……………………………………………

Lunch ……………………………………….
……………………………………………
……………………………………………
……………………………………………

Dinner …..
……………………………………………
……………………………………………
……………………………………………

Drinks……………………………………
…………………………………………..

Snacks……………………………………
……………………………………………
…………………………………………….

Day 2

Breakfast ……………………………………
……………………………………………
……………………………………………
……………………………………………

Lunch ……………………………………….
……………………………………………
……………………………………………
……………………………………………

Dinner …..
……………………………………………
……………………………………………
……………………………………………

Drinks……………………………………
…………………………………………..

Snacks……………………………………
……………………………………………
…………………………………………….

Portion examples.	Small	medium	large
Cheese cheddar	20g	40g	60g
Baked potato	100g	180g	220g
Carrots boiled	40g	60g	85g
Chips	100g	165g	240g
Peas	40g	70g	100g
Rice boiled	100g	180g	290g

Cheese grated 1 tablespoon = 10g
Savoury flan 1 slice 120g
Sponge cake 1 slice 60g
Pizza 1 slice 100g

Day 3

Breakfast ……………………………………
……………………………………………
……………………………………………
……………………………………………

Lunch ……………………………………….
……………………………………………
……………………………………………
……………………………………………

Dinner …..
……………………………………………
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Drinks……………………………………
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Snacks……………………………………
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Please leave blank ………………………..
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From your health concerns described on page 1 and health history on page 2 please provide further details for those conditions which are still current.

For example:
Allergies please detail if you have carried out any type of allergy/ sensitivity testing including dates and type of test.

Bowel problems, symptoms of irritable bowel can vary from patient to patient some experiencing constipation for other this may be an urgency or diarrhoea.

Sleep problems may be difficulty falling asleep or frequent waking.

Further symptom information: