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Stoneygate
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LE2 2LF

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Health and Dietary Questionnaire

Please complete and return by email to info@privategp.com or by post to Private General Practice Services, 3, Knighton Grange Road, Leicester, LE2 2LF to arrive no later than 48 hours prior to your appointment

Name First Last		Date of Appointment	
Title (Mr, Ms, Mrs, Miss etc)			

Occupation Part-time or full-time?		Date of birth Age	
Height Weight Your preferred weight			

	X for yes	*Further details*
Are you pregnant, or aiming to become pregnant?	☐	…….
Are you currently following a particular diet?	☐	…….
Are you currently seeing other therapists eg osteopath?	☐	…….

……

CURRENT HEALTH CONCERNS

Please list your main health concerns in order of priority, including how long you have been experiencing the problem and steps taken so far to alleviate it. (See also page 8).

Health Concern	Main Symptoms	Duration or frequency	Treatment or Medication	Date
EXAMPLE: *1. migraines* *2. acne rosacea*	*Have to stay off work* *Blotchy and red on nose/cheeks*	*Every 5-6wks* *2 years - most of the time*	*Migrileve* *Erythromycin*	*2001-now* *Since Jul08*
1.....	.....	.....	.....	.....
2.....	.....	.....	.....	.....
3.....	.....	.....	.....	.....

MEDICAL HISTORY

Please list *previous* health problems, including major operations/accidents. Continue on an additional sheet if necessary.

Health Problem	Duration	Medication/Investigations	Date
EXAMPLE: *abdominal pain*	*2 years*	*Paracetamol* *Appendix removed*	*1990-1992* *1992*

MEDICATIONS

Are there medications not mentioned above that you have taken over a length of time in the past, take currently or take from time to time? Please list.

Medication Name: Prescribed, or from chemist	Dosage	Condition being treated	Duration/Dates

SUPPLEMENTS

Please list (if any) nutritional supplements, herbals or homeopathic medicine that you are currently taking. Please continue on the back of the form if necessary. State type, brand name and strength.

Supplement:Name, Brand & strength	Dosage	Reason for taking	How long taken
…….	…….	……	……
…….	…….	……	……
…….	…….	……	……
…….	…….	……	……

FAMILY HISTORY

Please list any illnesses or conditions that family members have experienced:

Mother		**Maternal Grandmother**	
		Maternal Grandfather	
Father		**Paternal Grandmother**	
		Paternal Grandfather	
Aunt		**Uncle**	
Sister		**Brother**	

TOXICITY PROFILE

	Details here		*Details here*
SMOKING Do you smoke? How many? Did you smoke? From what age? For how many years? How many per day?		**ALCOHOL** Have you ever drunk heavily? Do you consider you currently drink socially in excess?	
DENTAL HISTORY How many amalgam (silver) fillings do you have? Have you had many dental problems?		**ENVIRONMENTAL TOXINS** Do/did you work, with chemicals e.g. paints, solvents, dry cleaning fluid? Other exposure?	

QUICK SYMPTOM SCAN

Please UNDERLINE or HIGHLIGHT any ailments that you regularly experience (ignore italics)

Head
headaches, migraine, stiff neck, fuzzy headed, *dizziness*, poor balance, pounding head, feeling of hangover, *unexplained pain*

Hair
oily, dry, poor condition, brittle, thinning, prematurely grey, dandruff, increased facial hair, increased body hair, decreased body hair

Mouth
sore tongue, tooth decay, mouth ulcers, bad breath, sore throats, poor sense of taste, excess saliva, dry mouth, *difficult swallowing,* hoarse voice, gingivitis, bleeding gums, cold sores

Eyes
burning, gritty, protruding, prone to infection, sticky, itchy, *painful*, poor night vision, dry, cataracts, sensitive to light, bags, swollen eyelids, *blurred vision*, double vision, failing eyesight, yellowish

Ears
blocked, sore, itchy, weeping, watery, overly waxed, creased earlobe

Nose
stuffy, congested, runny, *frequent nose bleeds*, prone to snoring, sinusitis, hay fever, post-nasal drip, rhinitis, sneezing, poor sense of smell

Muscles
Tender, sore, cramps, spasms, twitches, loss of tone, wasting, weak, stiff, frozen, 'restless legs', numbness

Skin
dry, rough, flaky, scaly, puffy, pale, brown patches, *change in moles or lesions*, prematurely lined, congested, oily, clammy, yellow

Skin prone to
acne, pimples, rosacea, eczema, dermatitis, psoriasis, rashes, boils, hives, itching, stretch marks, cellulite, easy bruising, thread veins, varicose veins, ringworm, allergic reactions, excessive sweating

Joints (fingers, knees, back, shoulders etc.)
painful, inflamed, swollen, stiff, rheumatic, arthritic, aching, sore, difficulty bending, reduced mobility, unsteadiness, slow movement

Mood *(please underline your predominant states – even if they conflict)*
depressed, anxious, tense, angry, happy, balanced, optimistic, sad, pessimistic, tired, can't be bothered, hyperactive, cheerful, agitated, easily upset, tearful, jittery, frightened, explosive, pent up, worried, annoyed, overwhelmed, *suicidal*, fluctuating, aggressive

Mind
forgetful, difficulty learning new things, easily confused, difficulty concentrating, easily frustrated, easily distracted, difficulty making decisions, can't switch off, loss of interest in daily life, fogginess, dyslexia, dyspraxia, hyperactive, panic attacks, no motivation

Chest
frequent colds and chest infections, asthma, bronchitis, diagnosed heart condition, palpitations, *chest discomfort/pain, short of breath*, difficulty breathing, wheezing, *persistent cough*, noisy breathing

Gut
bloated, tender, cramping, distended, nausea, sensation of fullness, acid reflux, heartburn, flatulence, belching, churning, *painful*, irritable bowel syndrome, celiac, hiatus hernia, diverticula, polyps, haemorrhoids, ulcers, sluggish, sensitive, *constipation, diarrhoea*

Genitals
itchy, cystitis, thrush, ulcers, warts, herpes, groin pain, prostatitis, pelvic inflammatory disease, impotence, painful intercourse, vaginal dryness, *painful or frequent urination*, unexplained discharge

Hands
dry, cracked eczema, sore joints, puffy, cold, chilblains, *numbness*, tingling, feel clumsy & uncoordinated, poor circulation

Nails
fragile, dry, brittle, flaky, peeling, splitting, hangnails (split cuticles), ridged, spoon shaped, white spots on more than 2 nails, horizontal white lines, thickened or horny, dark nails, pale nail bed, infected

Legs & Feet
restless legs, swollen, aching, athlete's foot, fungal nails, burning feet, tender heels, gout, sciatica, cold feet, tingling, *numb*, prick

YOUR LIFESTYLE

EXERCISE What physical activity do you do at home or at/after work? How long do you spend? How many times per week?		**STRESS** How stressful is your life at the moment? Score Lowest 1, highest 10 Do you get very impatient? Do you tend to bottle up your feelings? Are there any long-term stressful situations in your life?	
RELAXATION What hobbies do you have? What else do you do to relax?		**SLEEP** How many hours do you get? When do you go to sleep? When do you wake? Do you have difficulty falling asleep? Do you regularly wake?	

How motivated/confident are you to change your diet and lifestyle? Low confidence 1 2 3 4 5 6 7 8 9 10 High confidence

FEMALE PATIENTS ONLY

Do you get menstrual periods? Please give details:	Yes/no Regular/irregular Heavy/average/light Very painful /not too bad /not painful?	Have you had children? What is their year of birth?	
Please list any symptoms that usually occur *before* periods start e.g. bloating, cravings etc		Were there any problems with any pregnancy or delivery? e.g. morning sickness, forceps, C-section	
Do you get symptoms *during* your periods e.g. severe, cramps, clotting?		Do you have a regular cervical smear?	
What contraception do you, or have you used? How long have you, or did you, use this method?		Have you ever had breast cysts? Have you ever had ovarian cysts or fibroids?	
Have you ever had a miscarriage or termination?		Do/did you get menopausal symptoms? Please describe	

DIETARY HISTORY
Frequency of Different Foods

It is important that we are able to make a reasonable assessment of your current dietary intake and so please complete these pages by filling in how many portions (a portion can be a handful or cup) of the following foods that you eat?

FOOD GROUP	Per day	Per week	Per month	Comments, if any
Meat: beef, lamb, pork				
Chicken, turkey				
Meat products: bacon, ham, sausages, nuggets etc				
Meat products: salami, ham, cold processed meats				
Fish: Oily eg salmon				
White eg cod				Breaded/battered?
Eggs				
Dairy: Milk				Whole milk, semi- or skimmed?
Yoghurt				Flavoured, plain, biolive?
Cheese Hard/Soft				
Other milk: Rice/Oat/Soya				
Vegetables				Fresh, tinned or frozen?
Salad				Type?
Fruit				Fresh, tinned, dried?
Potatoes Baked/boiled/mash				
Nuts				Salted/roasted/fresh?
Seeds (pumpkin, sunflower)				
Lentils/beans (kidney, aduki, haricot, '3 beans', etc)				Baked beans?
WHEAT: Bread White/Brown/Wholemeal/Seeds				
Pasta				White or wholegrain? Wheat?
Cereal (brands bought?)				With milk? Sugar? Fruit? Seeds?
Cakes, biscuits, cereal bar				Describe
OTHER GRAINS: Rice, millet, quinoa, buckwheat, oats				White or brown rice?
OTHER SNACKS Chocolate, sweets Crisps Other (describe)				Describe

Please describe any dietary restrictions or known allergies/intolerances

Please mark *x* for the cooking methods you frequently use					
Boiling		Roast		Steam	
Grilling		Bake		Deep-fry	
Shallow-fry		Microwave		Stir-fry	

What type of fat do you use in cooking? butter, sunflower oil, olive oil, etc		**Do you add salt during cooking?** **Do you add salt at table?**	□ **Yes** □ **No** □ **Yes** □ **No**
Do you use artificial sweeteners?	□ **Yes** □ **No**	**List any foods you would find it difficult to live without**	

DO YOU BUY:	Daily	Per Week	Per month		Daily	Per Week	Per month
Ready Meals: Please describe				**Take-aways:** Please list			

ALCOHOL One small (125ml) glass of wine at 9% is 1 unit; red wine (175ml) at 14% is 2.5 units; 25ml pub measure of spirit at 40% is 1 unit; Half a pint of beer/lager/cider at 3.5% is 1 unit

Please indicate what alcoholic drinks you *typically* drink (in this column), and number of units each day (in columns to right)	**Mon**	**Tues**	**Wed**	**Thurs**	**Fri**	**Sat**	**Sun**

FOOD DIARY Please write a detailed description of EVERYTHING you eat and drink over a 4-day period (preferably include a weekend day). Please indicate whether it was home cooked, pre-prepared or from a restaurant/take away and how it was cooked e.g. baked, fried, roasted, grilled, steamed, microwaved etc. Please fill in exercise, relaxation and wellbeing sections and any symptoms. This provides a 'snapshot' of your current eating pattern, and is a useful starting point for our discussion.

	Day:	**Day:**	**Day:**	**Day:**
Wake time **Bed time**				
Breakfast **Time**				
Snack **Time**				
Lunch **Time**				
Snack **Time**				
Evening **Time**				
Snack **Time**				
Beverages **Type** **Total for day**				
Water **Total for day**				
Exercise/activity **Type** **How long** **Relaxation**				
Physical, Mental or Emotional Feelings or Symptoms				

Please use this box for additional information you think may be helpful for the consultation:

Thank you for completing the questionnaire and returning it at least 48 hours prior to your appointment. Please email to **info@privategp.com** or post to:

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