NUTRITION & LIFESTYLE QUESTIONNAIRE

Initials & Surname .....**Tel:** …… **Email:** .....

How many times a week have you consumed the following foods over the past 3 months? **[0] Never [1] Once a week [2] Twice a week [3] Three times a week** **[4] Four times a week [5] Five times a week [6] Six times a week [7] Everyday**			
Fast food combo meals except 'healthy' options		Biscuits, cake, cookies, croissants	
Red meat (e.g. beef, lamb, mutton)		All legumes (beans, peas, lentils)	
Fried chicken / cooked chicken with skin		Unpeeled potatoes cooked / baked	
Frozen pizza / sausages / bacon / pies		At least 5 portions fruits and vegetables (whole, salad, juiced)	
Salad dressings / mayonnaise (excluding '35-50% reduced fat' versions)		Whole / multigrain breads and cereals of wheat, oats, rye, barley, millet, quinoa and corn)	
Butter and margarine (excludes 'olive or plant sterol' versions)		Broccoli, artichoke, asparagus, spinach and other leafy green vegetables	
Eggs (excludes cooking and baking)		Yeast extract spread	
Full cream dairy products (ice cream, milk, cheese)		Avocado / oranges	
'Snacks' such as fried chips, crisps, buttered popcorn, droewors		Beef / chicken / turkey liver	

Further questions

Food allergy / intolerance	Prolonged exposure to environmental toxins (e.g. agricultural pesticides, occupational solvents) Y N If yes:_____
Food supplements taken daily	Food supplements taken occasionally
Food preferences such as vegetarian or vegan	Iron injections Y N Vitamin B12 injections Y N
Ethnicity ☐ Coloured ☐ Black ☐ Asian ☐ White ☐ Other. If other, please specify - _____	**Medication side effects?** Y N Cholesterol-lowering statins (e.g. muscle pains) Y N Anti-depressants (e.g. weight gain) Y N Immunomodulating drugs (e.g. depression) Y N Anti-retrovirals (e.g. weight gain, dyslipidaemia) **Other** (e.g. tamoxifen). Please specify medication & side effect: .....
Which best describes your physical activity status? (Includes walking, swimming, cycling, attending exercise classes, each lasting more than 30 minutes) ☐ Recreational sport occasionally or complete lack of exercise ☐ Recreational sport 1 time a week ☐ Exercise 2-3 times a week ☐ Exercise 4 or more times a week	**Which best describes your day-time or occupational activity?** ☐ Sedentary (desk work, driving, etc.) ☐ Moderate (housework, gardening, walk often) ☐ Intense physical labour (building, construction work etc.)

Initials & Surname .....Tel: …… Email: .....

(Females) Do you take? An oral contraceptive pill (OCP) Y N Current Y N Previous (If yes, please state duration of previous use: ……..) Hormone replacement therapy (HRT) Y N Current Y N Previous (If yes, please state duration of previous use: ……..) Y N Pregnant?	**Weight**…….... kg **Height**……..meters **Waist circumference** .....cm **Hip circumference** .....cm **Systolic blood pressure** …….....mmHg **Diastolic blood pressure** ……..mmHg
How many units of alcohol do you consume on average per week? One unit of alcohol equals 250 ml beer or larger, 1 glass (125 ml) of wine, 1 pub measure of spirits ☐ Abstain ☐ 1-2 units occasionally only ☐ 1-13 units ☐ 14-21 units ☐ 22 units or more	**Smoker?** Y N Current Y N Previous (less than 1 year) Y N Passive smoker **Are you currently a blood donor?** Y N

	Indication of Referral (please tick all that apply)	**Please specify reason for referral/condition**
☐	Previous diagnosis of a hereditary condition	
☐	At risk due to a high prevalence of a medical condition in family	
☐	Need to identify the cause of certain condition(s)	
☐	Health maintenance	
☐	Other	

PLEASE ALSO PROVIDE ANY AVAILABLE PATHOLOGY RESULTS (e.g. fasting lipogram, homocysteine, glucose, iron studies, hsCRP)

Please complete the family history questionnaire below (please note - this follows onto the next 2 pages)

FAMILY HISTORY QUESTIONNAIRE

PLEASE PROVIDE INFORMATION BELOW ON THE FOLLOWING MEDICAL CONDITIONS

Please tick if no family history due to adoption ☐

	Patient			**Family history**	
MEDICAL CONDITION	**PATIENT (Y/N)**	**MEDICATION**	**AGE OF ONSET**	**RELATIVE (Y/N). Please specify relationship e.g. mother/father etc**	**AGE OF ONSET**
Angina (chest pain or discomfort)					
Alzheimer's disease					
Anaemia / iron deficiency					
Arthritis / osteoarthritis					

Initials & Surname .....Tel: …… Email: .....

	Patient			Family history	
MEDICAL CONDITION	**PATIENT (Y/N)**	**MEDICATION**	**AGE OF ONSET**	**RELATIVE (Y/N). Please specify relationship e.g. mother/father etc**	**AGE OF ONSET**
Cancer (please confirm with your health practitioner, any information you are uncertain of)				Please list each relative, type of cancer & age of onset:	
	Type of cancer:				
	Cancer subtype / mutation e.g. BRCA 1, 2:				
	If breast cancer, ER ☐ PR ☐ HER2 ☐				
	Cancer recurrence – age(s)				
	Cancer metastasis – organ(s) affected				
Cardiomyopathy (diseases of the heart muscle)					
Cardiovascular disease					
Chronic fatigue					
Chronic inflammation					
Chronic periodontitis (inflammation of the tissue around the teeth)					
Coronary heart disease (angina, myocardial infarction)					
Deep vein thrombosis (blood clot within a deep vein)					
Dyslipidaemia					
Familial hypercholesterolemia					
Haemochromatosis / High blood iron					
High cholesterol					
High blood pressure					
Hypothyroidism					
Insulin resistance					
Ischaemic cerebrovascular disease (blocked blood vessel, usually from a clot formed from fat and cholesterol)					
Multiple sclerosis					

Initials & Surname .....Tel: …… Email: .....

	Patient	Family history			
MEDICAL CONDITION	**PATIENT (Y/N)**	**MEDICATION**	**AGE OF ONSET**	**RELATIVE (Y/N). Please specify relationship e.g. mother/father etc**	**AGE OF ONSET**
Metabolic syndrome (increased blood pressure, a high blood sugar level, excess body fat around the waist and abnormal cholesterol levels)					
Myocardial infarction (heart attack)					
Non-alcoholic fatty liver disease (accumulation of fat in the liver of people who drink little or no alcohol)					
Overweight/ Obesity					
Peripheral vascular disease (narrowing of arteries outside of the heart and brain by atherosclerotic plaques)					
Polycystic ovarian syndrome					
Porphyria/variegate porphyria					
Pulmonary embolus					
Recurrent pregnancy loss / Infertility					
Restless leg syndrome					
Schizophrenia					
Sleep apnoea (interrupted breathing during sleep)					
Stress, anxiety, depression					
Stroke					
Thrombosis					
Transient ischaemic attack (mini stroke)					
Type II Diabetes / high blood sugar					
Vascular dementia (common form of dementia caused by an impaired supply of blood to the brain)					
Other (specify)					