Health Questionnaire

CYTOPLAN

Personal Details

Name & Surname:

Date of Birth:

Gender: ☐ Male ☐ Female

Address & Postcode:

Telephone:

Job description:

Number of children: Ages:

Living circumstances:
☐ Living with spouse/partner ☐ Living alone ☐ Living with family relative(s)

Current blood pressure (if known):

Height: (cm / metres / feet) **Weight:** (lbs / kg / stone)

Reason(s) for completing the questionnaire today:

Health conditions / symptoms you are seeking support for:	How long have you had this?
1.	
2.	
3.	

Our reply will be sent to your email address (unless requested otherwise). Please print clearly.

Email address:

By signing below, you are confirming that you have read and understood the Health Questionnaire Terms of Reference attached to this questionnaire (see page 14).

Your Signature: **Date:**

Returning your Health Questionnaire

We will respond to your health questionnaire as soon as possible by post or email; telephone responses are not available. Please note health questionnaire support is not intended to replace a medical consultation or practitioner consultation. **If you have health concerns it is important to obtain a medical diagnosis for your symptoms.**

Please email your completed health questionnaire to healthq@cytoplan.co.uk

If returning by post to us, please mark on the envelope: FAO Nutrition Team.
Cytoplan Limited, Unit 8, Hanley Workshops, Hanley Swan, Worcester, WR8 0DX

Please note that questionnaires returned **by post may have to wait up to 2 weeks to receive a reply**. **Please ensure you use the correct postage i.e., a large stamp.** Otherwise, there may be a long delay.

Recent Consultations

Please provide approximate dates and details of any consultations:

	Date	Reason for visit	Diagnosis/ Treatments received
G.P.			
Medical Consultant			
Practitioner/ therapist **Therapy:**			

Please tick the box next to any of the following that apply to you:

Do you get any severe and/or persistent pain in any of the following:

☐ Head	☐ Eye
☐ Abdomen	☐ Temple
☐ Chest	☐ On passing urine

Other please write in:

Do you ever get blood in any of the following:

☐ Vomit	☐ Urine
☐ Stools	☐ Sputum

Have you recently had any changes in:

☐ Level of thirst	☐ Weight	☐ Appetite
☐ Skin	☐ Vision	☐ Bowel movements
☐ Urination	☐ Body/face shape	☐ Swallowing
☐ Breathing	☐ Personality/behaviour	

Your Health History

Have you now or in the past experienced any of the following? Tick if the answer is **YES**

Condition	**Now**	**Past**	Please provide further details of symptoms:
Allergies	☐	☐	
Anxiety	☐	☐	
Arthritis	☐	☐	
Asthma	☐	☐	
Bowel Problems	☐	☐	
Cancer	☐	☐	
Diabetes	☐	☐	
Depression	☐	☐	
Ear/eye/nose/throat	☐	☐	
Drug/alcohol dependence	☐	☐	
Epilepsy	☐	☐	
Eczema/skin conditions	☐	☐	
High blood pressure	☐	☐	
Heart conditions	☐	☐	
Osteoporosis/osteopenia	☐	☐	
Menstrual/menopause problems	☐	☐	

Stomach ulcers	☐	☐	
Sleep problems	☐	☐	
Urinary tract conditions	☐	☐	
Thyroid problems	☐	☐	

Other diagnosed conditions:

Digestive Function	
Do you experience any of the following?	Please provide details of any which occur regularly
☐ Abdominal bloating	
☐ Acid reflux	
☐ Bloating after meals	
☐ Burning pains in stomach	
☐ Burning pain in throat	
☐ Constipation	
☐ Diarrhoea	
☐ Diverticula	
☐ Flatulence belching	
☐ Flatulence rectal	
☐ Frequent urging to stool	
☐ Hemorrhoids	
☐ Irritable Bowel syndrome	

Female only

Please indicate if monthly menstruation is present: ☐ Yes ☐ No

Are you prescribed hormonal contraception or hormone replacement therapy?
Please provide drug names:

Additional menstrual information:

Are you trying to conceive or currently pregnant?

Surgical procedures: Please provide details of any surgery and approximate dates.

Prescribed Medicines: Please list all medications you are currently taking and include dose. This information is important to enable us to suggest safe and appropriate nutritional supplements for you. **Please continue on a separate sheet if needed.**

Name of Medication	What is it for?	Daily Dose

Non-prescribed Medicines: Please list any medications, laxatives, herbal products and/or homeopathic remedies that you take on a regular or frequent basis.

Supplements: Please list all supplements that you are taking **currently**, dose and brand names.

Please list any recently discontinued medications or supplements?

Family Medical History: Please provide details below of family health conditions. e.g., Angina, Alzheimer's, Arthritis, Asthma, Blood pressure, Cancer, Dementia, Diabetes, Heart disease, Lung disease, Osteoporosis, Parkinson's disease, Stroke.

Parents:

Grandparents:

Brothers/Sisters:

Nutrition and Diet

Present Diet: Please tick those boxes that relate to your present diet:

- ☐ Mixed food diet (animal and vegetable sources)
- ☐ Vegetarian
- ☐ Lacto vegetarian
- ☐ Lacto ovo vegetarian
- ☐ Salt restriction
- ☐ Fat restriction
- ☐ Starch/carbohydrate restriction
- ☐ Calorie restriction
- ☐ Other dietary plans, please detail-

Food exclusions: please list any foods you exclude from your diet. e.g. dairy, eggs, soy, wheat, gluten

Have you taken any food allergy/intolerance tests? Please state type of test undertaken and results

Food Frequency

Fruit: How many portions of fruit do you eat each day?

Name below those fruits that you eat regularly:		

Vegetables: How many portions of vegetables do you eat each day?

Name below those vegetables that you eat regularly:		

How many slices of bread do you eat per week of the following?		
White -	Wholemeal -	Granary -
Rye -	Wheat free -	Gluten free -

How many portions a week do you eat of the following? Please insert approximate number.		
Pulses, beans, lentils etc	Beef	Lamb
Pork	Chicken	Turkey
Eggs	Milk	Yoghurt
Cheese	White fish	Tuna
Salmon	Trout	Herring
Sardines	Mackerel	

What grains do you eat on a weekly basis? Tick boxes below.		
☐ Wheat	☐ Corn	☐ White rice
☐ White pasta	☐ Quinoa	☐ Millet
☐ Oats	☐ Rye	☐ Brown rice
☐ Wholemeal pasta	☐ Couscous	☐ Bulgar wheat

Eating Habits: Please tick all of the following which apply.

☐ Skip breakfast
☐ Graze (small frequent meals)
☐ Regularly miss meals
☐ Eat constantly whether or not hungry
☐ Generally eat on the run
☐ Add salt to food
☐ Add sugar to drinks. Number of teaspoons per drink -

Fluids:
Cups per **day** of:

Coffee	Tea	Green Tea	Herbal Teas	Decaffeinated tea or coffee

Fluids:
Cans/Glasses per **day** of:

Fizzy Drinks	Cordial	Fruit Juice	Sugar free diet drinks	Energy Drinks
Water glasses (250ml) per day		**OR** litres per day		

Other Habits:
Number per day:

Cigarettes	Cigars

Alcohol:

Wine (175 ml glasses)	Total per week -
Spirits (measures)	Total per week -
Beer, Lager, Cider (pints)	Total per week -

Exercise

How many days per week do you exercise?

☐ 1-2 days	☐ 2-3 days	☐ 4-5 days	☐ 6-7 days

Duration per session:

☐ less than 30 minutes	☐ 30-45 mins	☐ 45 mins or more

Please describe types of exercise undertaken on a regular basis:

How motivated are you to change the way you eat and to experiment with new foods?

☐ I am willing to try anything that might improve my condition

☐ I feel I can cope with a moderate amount of change

☐ I feel very anxious about changing my dietary/lifestyle habits

Please rate your motivation on a scale of 0 to 10 (0=low; 10=high):

Any additional information you wish to provide may be given below:

Please ensure you use the correct postage i.e. a large stamp. Otherwise, there may be a long delay in us receiving the questionnaire and we will be asked to pay the excess postage. Thank you.

Food Diary

Please write down all the foods and drinks you consume over a **3** day period, include **1** weekend day. Please complete as **accurately** and **honestly** as possible.

The following represents my diet for the: ☐ last month ☐ 6 months plus ☐ 1 year plus

Breakfast	**Lunch**	**Dinner**	**Snacks**	**Fluids** include alcohol
Day 1	Day 1	Day 1	Day 1	Day 1
Day 2	Day 2	Day 2	Day 2	Day 2
Day 3	Day 3	Day 3	Day 3	Day 3

Example

Breakfast	**Lunch**	**Dinner**	**Snacks**	**Fluids** Include alcohol
Day 1	Day 1	Day 1	Day 1	Day 1
Porridge with honey	Ham sandwich Crisps	Roast Chicken Carrots Peas Mashed potato Apple pie & custard	Crisps Chocolate bar Apple	Tea 4 cups Coffee 1 cup Water 1 glass Red wine 1 glass

MYMOP - Measure Yourself Medical Outcome Profile

The questionnaire below is used to measure changes in health outcomes following health recommendations. Recommendations should be followed for a period of 2-3 months, this enables us to identify any improvements or additional requirements to make appropriate recommendations as well as tracking effectiveness of recommendations. After this time, please contact HealthQ@cytoplan.co.uk to review your program. This data may be used for case studies, which will be completely anonymous and will not be used without permission of the client.

This form was developed from the MYMOP2 form from Bristol University http://www.bris.ac.uk/media-library/sites/primaryhealthcare/migrated/documents/initialform.pdf

Initials:	**Date:**

Choose one or two symptoms (physical or mental) which bother you the most. Write them on the lines.

Now consider how bad each symptom is, over the last week, and score it by circling or highlighting your chosen number.

Symptom 1:

0	1	2	3	4	5	6
As good as it could be						As bad as it could be

Symptom 2:

0	1	2	3	4	5	6
As good as it could be						As bad as it could be

Now choose one activity (physical, social or mental) that is important to you, and that your problem makes difficult or prevents you doing. Score how bad it has been in the last week.

Activity:

0	1	2	3	4	5	6
As good as it could be						As bad as it could be

Lastly how would you rate your general feeling of wellbeing during the last week?

0	1	2	3	4	5	6
As good as it could be						As bad as it could be

How long have you had Symptom 1, either all the time or on and off? Please circle:

0 - 4 weeks	4 - 12 weeks	3 months - 1 year	1 - 5 years	over 5 years

Health Questionnaire Service – Terms of Engagement

Health Questionnaire Service: This free service, which is available from our in-house Registered Nutritional Therapist, is offered to our customers as we recognize the importance of diet, lifestyle and choosing appropriate supplements as important to support health improvement. Offering this no obligation service is also in line with our charitable objectives; we are wholly owned by a charitable foundation that supports environmental and health improvement projects globally. If you complete and return the attached questionnaire, our Registered Nutritional Therapist will send you some written diet and supplement recommendations to support your health goals. **However, please be aware that as a postal questionnaire we are limited in the suggestions and support we can provide**.

The Nutritional Therapist requests that the client notes the following:

- The degree of benefit obtainable from the recommendations may vary between clients with similar health problems and following a similar programme.
- Nutritional advice will be tailored to support health conditions and/or health concerns identified on the health questionnaire.
- We are not permitted to diagnose, or claim to treat, medical conditions.
- Nutritional advice is not a substitute for professional medical advice and/or treatment.

The client understands and agrees to the following:

- You are responsible for contacting your GP about any health concerns.
- If you are receiving treatment from your GP or any other medical provider you should tell him/her about any nutritional strategy provided by a Nutritional Therapist. This is necessary because of any possible reaction between medication and the nutritional programme.
- It is important that you tell your Nutritional Therapist about any medical diagnosis, medication, herbal medicine or food supplements you are taking as this may affect the nutritional programme.
- If you are unclear about the agreed programme / food supplement doses / time period, you should contact your Nutritional Therapist promptly for clarification.
- You must contact your Nutritional Therapist should you wish to continue any specified supplement programme for longer than 2 months, to avoid any potential adverse reactions. In any case we recommend a regular review of supplements to ensure they remain appropriate for your needs.
- You are advised to report any concerns about your programme promptly to your Nutritional Therapist for discussion / action.
- Please note we do recommend that all supplements are taken at different times of the day to any prescribed medications.

We would always recommend you discuss any dietary or supplemental concerns or changes you wish to make with your G.P. Medication should never be discontinued or dosage amended without your G.P.'s prior knowledge and agreement.

I understand the above and agree that the health questionnaire service provided by Cytoplan Ltd will be based on the content of this document. We declare that all the information we share on this health questionnaire is confidential and, to the best of our knowledge, true and correct.

Name of client:

Client signature:

Date: