

NUTRITIONAL HEALTH APPRAISAL

Name: _____ D.O.B: _____ Appointment date: _____

Address: _____

What is the main reason for attending our clinic? _____

Please complete all sections of this questionnaire:

TOPIC	HAVE YOU EVER HAD:	NEVER	IN THE PAST	RECENTLY	FREQUENTLY
DIGESTION	Heartburn or reflux				
	Bloating after meals				
	Constipation				
	Burping or wind				
	Diarrhoea or loose stools				
	Nausea (feel like vomiting)				
	Stomach ulcers or Stomach pain				
LUNGS	Gall bladder problems				
	Asthma or Emphysema				
	Pneumonia or Bronchitis				
	Wheezing after a viral infection				
IMMUNE SYSTEM	Wheezing after exercise				
	Boils				
	Cold sores				
	Conjunctivitis				
	Ear infections				
	Genital infections				
	Mouth ulcers				
	Sinus infections				
	Sore throat				
	Thrush				
	Tonsillitis				
SKIN, HAIR & NAILS	Urinary infections				
	Acne or pimples				
	Brittle nails				
	Dry eyes or mouth				
	Dry skin				
	Eczema or Dermatitis				
	Early greying of hair				
	Hair loss				
	Psoriasis				
	Rashes				
	Sore or cracked lips				
	Tinea or ringworm				
	Stretch marks				
GYNAECOLOGICAL	White spots on nails				
	Warts				
	Abnormal pap smears				
	Breast cyst or lump(s)				
	Breast tenderness				
	Endometriosis				
	Fibroids				
	Ovarian cysts				
PMS/PMT					
ALLERGIES	Been on HRT				
	DO YOU HAVE ANY KNOWN ALLERGIES TO:	NO	YES	LIST	
	Medications				
	Foods or herbs				
	Hay fever or sinus trouble				
	Nasal blockage				
Other					

TOPIC	HAVE YOU EVER HAD:	NEVER	IN THE PAST	RECENTLY	FREQUENTLY
URINARY	Cystitis or kidney infections				
	Prolapse				
	Stones				
HEART	Angina or chest pains				
	Cold hands and feet				
	Fluid retention				
	Heart attack				
	Heart failure				
	Heart murmur				
	High blood pressure				
	Palpitations or Irregular heart rate				
SLEEP	Disrupted sleep				
	Insomnia				
	Snoring				
	Unrefreshed sleep				
NERVOUS SYSTEM	Agitation or anxiety				
	Irritability				
MUSCLE SYSTEM	Migraine or other headaches				
	Poor night vision				
	Gout				
	Dizziness or vertigo				
	Facial twitching				
	Fidgeting or restless legs				
	Fits or seizures				
	Blurred vision				
	Leg/foot or hand cramps				
	Loss of balance				
	Depression				
	Memory loss				
	Chronic pain				
	Mood swings or irritability				
	Muscle pain				
	Muscle weakness/heaviness				
	Pins & needles/Numbness				
	Poor concentration				
	Poor balance				
	Tinnitus (ringing in the ears)				
Tremor of the hands					
Weakness of a limb					
HAVE YOU EVER SUFFERED FROM:		NO	YES	YEAR	
LIVER PROBLEMS	Hepatitis or jaundice				
	Abnormal Function tests				
	Liver damage or fatty liver				
BLOOD DISORDERS	Anaemia				
	Low platelet count				
	Iron deficiency				
	Easy bruising				
	Low white cell count				
	Blood clots - Deep vein thrombosis				
	Blood clots - Pulmonary embolus				
HAVE YOU EVER HAD CANCER?		NO	YES	YEAR	
CANCER	Melanoma or other skin cancer				
	Breast				
	Ovary or uterus				
	Lung				
	Lymphoma or Leukaemia				
	Stomach or colon				
Other		List:			

TOPIC	HAVE YOU EVER SUFFERED FROM?	NO	YES	YEAR
VIRAL	Candida			
	Chronic Fatigue Syndrome			
	Helicobacter infection			
	Glandular fever			
	Leaky gut syndrome			
	Mycoplasma			
	Oral or genital herpes			
	Ross river virus			
JOINTS	Shingles			
	Osteo arthritis			
	Rheumatoid arthritis			
	Gout			
	Lupus			
	Ankylosing spondylitis			
WEIGHT	other			
	Overweight			
	Anorexia/bulimia			
OTHER	Weight loss			
	Diabetes			
	Thyroid problems			
	HAVE YOU EVER HAD AN ACCIDENT?	NO	YES	
ACCIDENTS	Car			
	Plane			
	Motorcycle			
	Marine			
	Bicycle			
	Industrial			
	Work			
	Sport			

Do you take prescription medications? *if so, please list*

Do you or have you ever smoked?

Do you take any naturopathics? *if so, please list*

Do you know your blood group? *if so, please list*

Do you take any vitamin or mineral supplements? *if so, please list*

Have you had any operations? *if so, please list*

Have you been on medication in the past? *if so, please list*

Do any foods upset you? *if so, please list*

Do you feel tired after eating?

Are there any diseases that run strongly in your family? *if so, please list*

Are you a vegetarian?

How many doctors have you seen about your problem so far?
