The Endometriosis and Fertility Clinic

"Let food be your medicine and medicine be your food"
Hippocrates (460 BC)

Nutrition Therapist and Director
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Please print this document, complete it as best as you can and bring it with you to your consultation. For postal/telephone consultations please send it as directed. Dian@endometriosis.co.uk

Private and Confidential

This document is Private and Confidential and the information provided is for the inclusive use of The Endometriosis and Fertility Clinic, Our commitment to you is to provide the most appropriate treatment for your needs. This questionnaire is designed to provide your nutritional therapist with all the information necessary to build you an individual nutritional programme specifically tailored to your needs. Please answer the questions as accurately as you can.

First Name:_____ **Last Name**: _____

Address:_____

_____**Post Code/Zip:** _____

eMail: _____

Telephone Number:(Work)_____ (Home)_____(mobile)_____

Occupation: _____ **Date of Birth:** _____

What is your Weight (without clothes):_____Stone _____lbs or _____kg **Has your weight changed recently?** _____

What is your Height (without shoes):_____feet _____ inches or _____cm

If you have had other clinical test, then please bring relevant copies of those results with you to the clinic

How did you hear about The Endometriosis and Fertility Clinic? _____

What other Complementary Therapies have you tried? _____

Which therapies did you find most helpful? _____

Doctor's Name: _____ Address: _____

_____ Tel: _____

Consultant's Name: _____ Address: _____

_____ Tel: _____

Do you give permission for your medical Doctor to be contacted? ____Yes / No_____

Number of Doctors seen _____ Number of Consultants seen _____

Health Profile

Please make a list of all the health problems you would like to clear up, and indicate how long you have had these problems eg: Headaches 5 years (Continue on a separate sheet if you need more space)

Health problem	Duration	GP consulted?
1		
2		
3		
4		
5		
6		

What medications (pharmaceutical drugs) **do you take for these?** State daily dose_____

_____

What Nutritional Supplements do you take for these regularly? State product name, manufacturer, dailydose.

_____

_____

Under what circumstances do these problems improve? _____

Under what circumstances do they get worse?_____

What other illness have you had in the past ten years?_____

What operations have you had (give dates**)?** _____

Have you been misdiagnosed? If so what with? _____

What is your normal blood pressure? (don't worry if you don't know) _____

What is your resting pulse rate per minute?_____

(You should be sitting down, relaxed and calm when you take your pulse. Your pulse can be found inside the boney protuberance on the thumb side of your wrist. Count the number of beats in 60 seconds.)

Heredity Profile

Do you have any children?

Child sex	Age	Illness

How many brothers and sisters do you have?

Sex	Age	Illness

Does anyone in your family have the following (tick those that apply**)**

Asthma		eczema		hayfever		arthritis	
diabetes		Coeliac disease		Thyroid problems		Irritable bowel syndrome	
migraines		cancer		osteoporosis		Any allergies	

What illness is/was your father prone to? _____

What illness is/was your paternal grandfather prone to? _____

What illness is/was your paternal grandmother prone to? _____

What illness is/was your mother prone to? _____

What illness is/was your maternal grandfather prone to? _____

What illness is/was your maternal grandmother prone to? _____

Symptom Analysis

Each question in this section starts with a list of symptoms associated with vitamin or mineral deficiency. Tick the box by the conditions you often suffer from. Some symptoms are repeated. **Please underline them in all cases.**

Mouth ulcers
Poor night vision
Acne
Frequent colds or infections
Dry flaky skin
Dandruff
Thrush or cystitis
Diarrhoea

Rheumatism or arthritis
Back ache
Tooth decay
Hair loss
Excessive sweating
Muscle cramps or spasms
Joint pain or stiffness
Lack of energy

Lack of sex drive
Exhaustion after light exercise
Easy bruising
Slow wound healing
Breast tenderness
Hot flushes
Varicose veins
Loss of muscle tone
Backache
Sub-fertility

Frequent colds
Lack of energy
Frequent infections
Bleeding or tender gums
Easy bruising
Nose bleeds
Slow wound healing
Red pimples on skin

Tender muscles
Eye pains
Irritability
Poor concentration
'Prickly legs'
Poor memory
Stomach pains
Constipation
Tingling hands
Rapid heart beat

Burning or gritty eyes
Sensitivity to bright lights
Sore tongue
Cataracts
Dull or oily hair
Eczema or dermatitis
Split nails
Cracked lips

Lack of energy
Diarrhoea
Insomnia
Headaches or migraines
Poor memory
Anxiety or tension
Depression
Irritability
Bleeding or tender gums
Acne

Loss of hair colour
Muscle tremors or cramps
Apathy
Poor Concentration
Burning feet or tender heels
Nausea or vomiting
Lack of energy
Exhaustion after light exercise
Anxiety or tension
Teeth grinding
Clumsiness/poor coordination

Low Blood Pressure / dizziness
Infrequent dream recall
Water retention
Tingling hands
Depression or nervousness
Irritability
PMS
Muscle tremors or cramps
Lack of energy
Flaky skin

Poor hair condition
Eczema or dermatitis
Mouth over sensitive to hot or cold
Irritability
Anxiety or tension
Lack of energy
Constipation
Tender or sore muscles
Pale skin

Eczema
Cracked lips
Prematurely greying hair
Anxiety or tension
Poor memory
Lack of energy
Poor appetite
Stomach pains
Depression

Dry skin
Poor hair condition
Prematurely greying hair
Tender or sore muscles
Poor appetite or nausea
Eczema or dermatitis

Dry, rough skin
Dry eyes
Frequent infections
Poor memory
Loss of hair or dandruff
Excessive thirst
Poor wound healing
PMS or breast pain
Sub-fertility

Muscle cramps or tremors
Insomnia or nervousness
Joint pain or arthritis
Tooth decay
High blood pressure
Muscle tremors or spasms
Osteoporosis

Muscle cramps or tremors
Muscle weakness
Osteoporosis
Insomnia or nervousness
High blood pressure
Irregular heart beat
Constipation
Fits or convulsions
Hyperactivity
Depression

Pale skin
Sore tongue
Fatigue or listlessness
Loss of appetite or nausea
Heavy periods or blood loss
Itchy legs
Pale inner eyelids
Difficulty swallowing

Poor sense of taste or smell
White marks on more than two finger nails
Frequent infections
Stretch marks
Acne or greasy skin
Sub-fertility
Pale skin
Tendency to depression
Poor appetite

Muscle twitches
Childhood 'growing pains'
Dizziness or poor sense of balance
Fits or convulsions
Sore knees
Sub-fertility

Family history of cancer
Signs of premature ageing
Cataracts
High blood pressure
Frequent infections
Dandruff

Excessive or cold sweats
Dizziness or irritability after 6 hours without food
Need for frequent meals
Cold hands
Need for excessive sleep or drowsiness during the day
Excessive thirst
'Addicted' to sweet foods
High Cholesterol

Lack of energy
Hair falling out
Difficulty swallowing
Weight gain
Constipation
Loss of 1/3 eyebrows
Loss of hearing
Feeling cold
Shaking hands

Low energy
Gum disease
Headaches
Insomnia
Irregular heartbeat
Heart disease

Osteoporosis
Inflammation
Osteoarthritis
Joint pains
Menopausal symptoms

Nervousness
Poor taste
Low energy

Cardiovascular Profile
Is your blood pressure above 140/90?
Is your pulse after 15 minutes rest above 75?
Are you more than 14lbs (7kg) over your ideal weight?
Do you smoke more than 5 cigarettes a day?
Do you do less than two hours exercise a week?
Do you have a pain in your calves on walking?
Do you eat more than one spoon of sugar a day?
Do you eat meat more than 5 times a week?
Do you usually add salt to your food?
Do you have more than 2 alcoholic drinks a day?
Is there a history of heart disease in your family?
Do you have tightness/chest pains?
Do you have high cholesterol?
Do you have high homocysteine?
Do you have swollen ankles?

Exercise Profile
Do you take exercise that noticeably raises your heart beat for 20 minutes more than 3 times a week?
Does taking exercise cause pain/exhaustion?
Does your job involve vigorous activity?
Do you regularly play sport? (football, squash, etc)
Do you have any physically tiring hobbies? (gardening, yoga, aerobics, etc)
Do you consider yourself fit?
Do you have an active job daily?

Pollution Risk Profile
Do you live in a city or by a busy road?
Do you spend more than 2 hours a week in traffic?
Do you exercise (job, cycle, play sports) by a busy road?
Do you smoke more than 5 cigarettes a day?
Do you live or work in a smoky atmosphere?
Do you buy foods exposed to exhaust fumes?
Do you generally eat non-organic produce?
Do you drink more than 1 unit or oz of alcohol a day? (1 glass of wine, 1 pint of beer, or 1 measure of spirits)
Do you spend a lot of time in front of a TV or VDU?
Do you usually drink unfiltered tap water?
Do you have mercury fillings in your teeth?

Stress Profile
Do you have low self esteem?
Does stress make you feel exhausted?
Is your energy less now than it used to be?
Do you feel guilty when relaxing?
Do you have a persistent need for achievement?
Are you unclear about your goals in life?
Are you especially competitive?
Do you work harder than most people?
Do you easily become angry?
Do you often do 2 or 3 tasks simultaneously?
Do you get impatient if people or things hold you up?
Do you have difficulty getting to sleep?
Do you wake too early?
Have you had a personal loss/trauma in the past year?

Respiratory Profile
Do you cough at night?
Do you suffer shortness of breath with exercise?
Do you have recurrent chest infections or sinus problems?
Do you work in a smoky environment?
Do you wheeze?

Glucose Tolerance Profile
Do you crave any particular foods? (name them)
_____
Do you need more than 8 hours sleep a night?
Are you rarely wide awake within 20 minutes of rising?
Do you need something to get you going in the morning, like a tea, coffee or cigarette?
Do you have tea, coffee, sugar containing foods or drinks, or cigarettes at regular intervals during the day?
Do you often feel drowsy during the day?
Do you get dizzy or irritable if you don't eat often?
Do you avoid exercise due to tiredness?
Do you sweat a lot or get excessively thirsty?
Do you sometimes lose concentration?
Is your energy less now than it used to be?

Muscular/Skeletal Profile
Do you have lower back pain?
Do you have joint pain/stiffness?
Do you have osteoporosis?
Have you had bone fractures?

Digestion Profile
Do you chew your food thoroughly?
Do you sometimes suffer from bad breath?
Are you prone to stomach upsets?
Are you prone to piles?
Do you often get a burning sensation in your stomach?
Do you find it difficult digesting fatty foods?
Do you occasionally use indigestion tablets?
Which foods give you indigestion? _____
Do you suffer from flatulence or bloating?
Do you experience anal irritation?
Do you have a bowel movement daily?
Do your stools float?
Do your stools contain blood, mucus, yellow & oily?
_____
Do you regularly suffer from diarrhoea? Linked with menstruation?
Do you regularly suffer from constipation? Linked with menstruation?

Pain Profile
Is your pain:

a) sharp, stabbing, lacerating, cutting, skewering
b) hot, burning, intense, overwhelming
c) wringing, twisting, taut, yanking
d) deep aches, mild cramps, killer cramps
e) excruciating, breathe taking, can't move
f) just discomfort or mild twinges

Immune Profile
Do you get more than three colds a year?
Do you find it hard to shift an infection (cold or otherwise)?
Are you prone to thrush or cystitis?
Do you often take antibiotics more than twice a year?
Is there a history of cancer in your family?
Have you ever had any growths or lumps biopsied?
Do you have an inflammatory disease such as eczema, asthma or arthritis?
Do you suffer from hayfever?
Do you suffer from allergy problems?
Have you had a major personal loss in the last year?

Nervous System Profile
Do you have fainting episodes?
Do you go dizzy or loose your sense of balance?
Do you have a ringing in your ears?
Have you ever had any seizure or epilepsy?
Are you prone to depression/despair/low mood swings?
Do you have any obsessions or feel overly suspicious?
Do you have poor concentration or short memory?
Do you have hot feet, cracked heels, teeth grinding?

Skin Profile
Do you have dry skin?
Do you have acne?
Do you have eczema?
Do you have psoriasis?
Do you have flaky skin?
Do you have greasy skin?
Do you have dermatitis?
Do you have boils?
Do you have cysts?
Do you have warts?
Do you have a verruca?

Weight Profile
Do you have an inability to gain weight?
Do you have an inability to lose weight?
Is your weight static?
Is your weight gain – central – back – hips/thighs?
Do you have unexplained weight loss?
Do you have unexplained weight gain?
Do you have unexplained weight gain?

Histamine Profile
Underline the following that applies to you:

Low	High
Sleep over 8 hours, little sex drive, much body hair, infrequent colds, sluggish metabolism, slow to wake up, short toes and fingers, suspicious by nature, fat or 'well covered', can tolerate pain.	Sleep less than 7 hours, strong sex drive, little body hair, family history of allergies, fast metabolism, 'morning person', long toes and fingers, tends towards depression, don't put on weight, poor tolerance of pain.

Allergy Profile
Do you suffer from any of the following? Please underline.
Nasal problems, hay fever, eczema, dermatitis, asthma, migraine, irritable bowel syndrome, frequent bloatedness, facial puffiness.
Do you have any allergies? _____ If so what? Food: _____ Chemicals: _____
State type of reaction. _____
Have they been tested? _____
What foods or drinks would you find hard to give up?
_____

Additional Questions for Men Only
Is your sperm count normal? _____
Is your sperm motility normal? _____
Is your erectile function normal? _____
Do you have difficulty urinating? _____
Does your urine flow weakly? _____
Is your hair receding? _____
Is your hair prematurely grey? _____

Childhood illnesses
Please state: _____

_____

Food dislikes: _____

_____

Additional Questions for Women Only
At what age did your periods begin?
At what age did you take an OCP?
Did you have any side effects from the OCP?
Are you pregnant? If so how many weeks? _____
Are you trying to become pregnant?
Have you ever had a miscarriage?
Do you have a coil fitted, or use the birth control pill? State which _____
Are you post-menopausal?
Have you had a hysterectomy?
Have you had your ovaries removed?
Have you ever taken HRT?
If so then for how long?
Do you suffer from any pre-menstrual bloatedness, tiredness, irritability, depression, breast tenderness, headaches *(Please underline)*

Period Profile
Are your periods regular?
Is your cycle 28 days? ____ Other: ____
Duration of bleed? _____days_light, heavy, flooding
Colour of blood? Red brown black –liquid, tarry
Are there clots (y/n)? ____

Endometriosis Profile
Do you have abdominal pain?
Do you have period pain?
Do you have ovary pain?
Do you have painful intercourse?
Do you have mid-cycle bleeding?
Do you have heavy periods?
Do you have ovarian cysts?
Do you have adhesions?

PCOS Profile
Do you have acne?
Do you have irregular periods?
Do you have hirsuitism (abnormal hair growth)?
Do you have male pattern baldness?
Do you have brown skin patches?
Do you have weight gain on hips, thighs, stomach?

Obstetric Profile
Have you had a miscarriage?
Have you had IUI or IVF treatment?
Dates_____
Have you had complications in pregnancy?
Have you had complications during labour?
Have you had an abnormal smear result?
Did you have a normal delivery?
Did you breast feed?

Diet Analysis

Please tick the questions to which you would answer 'yes' or fill in the 'number of times' you eat the food referred to in the question.

1. Are you vegan, vegetarian, picine vegetarian (eats fish)? __
2. Were you breast feed? _____
3. Was a significant percentage of your diet as a child high in fatty foods and sugar? _____
4. Do you go out of your way to avoid foods containing preservatives or additives? _____
5. Do you avoid foods which contain sugar? _____
6. How many teaspoons of sugar do you add to food/drinks each day? _____
7. Do you use salt in your cooking? _____
8. Do you add salt to your food? _____
9. How many coffees do you drink each day? _____
10. How many cocoas do you drink each day? _____
11. How many cups of tea do you drink each day? _____
12. How many times a week do you have meals containing fried food? Deep fat / stir fries? _____
13. What type of butter or margarine do you use? _____
14. What type of cooking oil do you use? _____
15. What type of salad dressing do you use? _____
16. What type of butter or margarine do you use? _____
17. How many packets of 'instant' or fast foods do you eat each week? _____
18. How many times a week do you eat chocolate or confectionary? _____
19. What percentage of your diet is **raw** fruit and **raw** vegetables? _____
20. Do you wash fruit and vegetables before eating? _____
21. Do you normally eat white rice or flour? _____
22. How many cans of food do you eat per week? _____
23. How many slices of bread or rolls do you eat each week?
24. How many pints of milk do you drink in a week? _____
25. How much cheese do you eat weekly? _____
26. How many times a week do you eat red meat? *(beef, pork, lamb or game)* _____
27. How many times a week do you eat white meat? *(chicken, turkey, duck, fish)* _____
28. What type of fish do you eat? _____
29. Do you eat tofu or quorn? _____
30. What is your usual alcoholic drink?_____
31. How many glasses do you drink a week? _____
32. How many fizzy drinks do you drink each week? _____
33. How many times a week do you eat live yoghurt? _____
34. How many eggs do you eat in a week? _____
35. Do you use a water filter or drink bottled water instead of tap water? _____
36. Do you frequently eat under stressful conditions or on the move? _____
37. Does your job involve eating out a lot? _____
38. Do you eat ion a café/restaurant more than three times a week? _____
39. What foods do you avoid as they upset you? _____
40. How would you describe your appetite?
    a) Poor b) average c) good

Sample Diet

Write down all the foods and drinks consumed over the next two days, starting today. Please add as much information as possible including quantities eaten brand names, and whether the food is fresh or packaged, refined or natural.

Day 1

Breakfast

Lunch

Dinner

Snacks/Drinks

Day 2

Breakfast

Lunch

Dinner

Snacks/Drinks

Are these two days representative of your usual eating habits? If not, what is a more usual day?

Breakfast

Lunch

Dinner

Snacks/Drinks

I agree to the above information being used by the Nutritional Therapist and the Endometriosis and Fertility Clinic for research purposes.

Signed: _____

I, _____, the Nutritional Therapist promise to work to the best of my ability to improve your health.