Nutritional Medicine dietary and health questionnaire

Patient code:		Date of consultation:	
Date of birth ----/----/-----	Gender: Female/Male	Weight _____kg	Height _____
Occupation _____		Marital status _____	

General information: list your main health concerns in order of your need to change, stating how long you have experienced the problem, stating medication prescribed or any tablets or pills you have been taking to help relieve the symptoms:

Why are you attending this consultation?

Presenting condition/symptoms		**Duration**	**Medication**
1			
2			
3			

Please list all medication you have taken in your life e.g. antibiotics, pain relief, anti-inflammatory, contraceptive pill, asthma medicine, HRT etc…

Name of medication	**Year**	**Reason**	**Duration and dosage**

List any nutritional supplements or herbs you are currently taking:

Name of supplement	Reason	Dosage

When did you last visit your GP and why?

Please list any major incidents such as accidents, surgery, dental work etc:

Year	Details of incident/s

Family History
Please provide health issues of family members

Mother		Maternal Grandmother	
		Maternal Grandfather	
Father		Paternal Grandmother	
		Paternal Grandfather	

Sibling illnesses

Brother/sister	Illness and dates or age

Bowels	**Urinary system**
Please tick below, how regularly do you open you bowels: More than twice a day ☐ Twice a day	Please state if you have suffered with the following in the last five years: Thrush ☐ Cystitis ☐

Once a day ☐ Once every two days ☐ Less than 3 times a week ☐	Prostate problems ☐ Frequent urination ☐
Do you ever have blood or mucous in your stools? Yes/No	If yes please state when and duration

Dietary history - childhood

Please provide details of your diet as a child
Breakfast Lunch   Dinner   beverages

List foods you are allergic/intolerant to or cause you bloating, gas or digestive problems
_____ _____ _____

Rate how stressed you have been in an average week over the past month

Low 1 2 3 4 5 **6 7 8 9 10** **High**

Rate how motivated you are to improve your health by changing your diet and lifestyle

Not motivated 1 2 3 4 **5 6 7 8 9 10** **Very Motivated**

List your two favourite foods and how often you eat them either daily or weekly

_____

_____

_____

Food diary:
Please provide a 4 day food diary ensuring the weekends are included

_____

Day 1 (Thursday)

Breakfast……..

Lunch……

Dinner……..

Beverages…….

Alcohol (please state type and quantity)…….

Snacks……..

Day 2 (Friday)

Breakfast……..

Lunch……

Dinner……..

Beverages…….

Alcohol (please state type and quantity)…….

Snacks…….

Day 3 (Saturday)

Breakfast……..

Lunch……

Dinner……..

Beverages…….

Alcohol (please state type and quantity)…….

Snacks……..

Day 4 (Sunday)

Breakfast……..

Lunch……

Dinner……..

Beverages…….

Alcohol (please state type and quantity)…….

Snacks……..

Additional information:

Please use this space for general dietary questions relating to confusion from media coverage or for any information that would help you get the most out your consultation:
