



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:** _____ **Sex: M/F** ____

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 consulted?	Duration	GP
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 bony protuberance on the thumb side of your wrist. Count the number of beats in 60 seconds.)

Heredity Profile

Do you have any children?

How many brothers and sisters do you have?

Child sex	Age	Illness

Sex	Age	Illness

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

Asthma	<input type="checkbox"/>	eczema	<input type="checkbox"/>	hayfever	<input type="checkbox"/>	arthritis	<input type="checkbox"/>
diabetes	<input type="checkbox"/>	Coeliac disease	<input type="checkbox"/>	Thyroid problems	<input type="checkbox"/>	Irritable bowel syndrome	<input type="checkbox"/>
migraines	<input type="checkbox"/>	cancer	<input type="checkbox"/>	osteoporosis	<input type="checkbox"/>	Any allergies	<input type="checkbox"/>

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:

- sharp, stabbing, lacerating, cutting, skewering
- hot, burning, intense, overwhelming
- wringing, twisting, taut, yanking
- deep aches, mild cramps, killer cramps
- excruciating, breathe taking, can't move
- 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?

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 hirsutism (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, piscine 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. How many packets of 'instant' or fast foods do you eat each week? _____
17. How many times a week do you eat chocolate or confectionary? _____
18. What percentage of your diet is **raw** fruit and **raw** vegetables? _____
19. Do you wash fruit and vegetables before eating? _____
20. Do you normally eat white rice or flour? _____
21. How many cans of food do you eat per week? _____
22. How many slices of bread or rolls do you eat each week? _____
23. How many pints of milk do you drink in a week? _____
24. How much cheese do you eat weekly? _____
25. How many times a week do you eat red meat? (*beef, pork, lamb or game*) _____
26. How many times a week do you eat white meat? (*chicken, turkey, duck, fish*) _____
27. What type of fish do you eat? _____
28. Do you eat tofu or quorn? _____
29. What is your usual alcoholic drink? _____
30. How many glasses do you drink a week? _____
31. How many fizzy drinks do you drink each week? _____
32. How many times a week do you eat live yoghurt? _____
33. How many eggs do you eat in a week? _____
34. Do you use a water filter or drink bottled water instead of tap water? _____
35. Do you frequently eat under stressful conditions or on the move? _____
36. Does your job involve eating out a lot? _____
37. Do you eat in a café/restaurant more than three times a week? _____
38. What foods do you avoid as they upset you? _____
39. 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.