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		

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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, daily dose.

_____

_____

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 or tick 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 / 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 daytime _
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? _____

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? _____

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? _____

Childhood illnesses
Please state: _____
_____

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? _____
Have you caught COVID-19? ____How many times? ____
What symptoms did you suffer from? _____
Do any symptoms remain? _____
How many COVID-19 vaccinations have you had? _____

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? _____

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 _

Histamine Profile
Underline or tick 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 or tick.
Nasal problems _, hayfever _, 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?
_____

Food dislikes: _____
_____

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? _____

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 or tick)*

Period Profile
Are your periods regular? _____
Is your cycle 28 days? ____ Other: ____
Duration of bleed? _____days, light_, heavy_, or 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.