Peatfield Clinic of Nutrition

Metabolic Health Questionnaire

Name: ……..

Address: ……

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Telephone Number: …… **Fax Number:** ……

Email:……

Sex: ❑ **M** ❑ **F** **Date of Birth:** ……. **Age:** …… **No. of Children (if any):** ……

Relationship Status: (please tick) ❑ **Married/Living with partner** ❑ **Divorced/Separated** ❑ **Single**

Occupation: ……

Hobbies: ……..

Medical history: ……..…

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Menstrual and obstetric history (age periods began, normal, abnormal, pregnancies, birth weight and problems): ……..……

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Present symptoms (see list on following page and use if required):……....

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SYMPTOMS LIST

Name: Date:

PHYSICAL

General:
- ❑ Excessive tiredness
- ❑ Weight gain
- ❑ Weight loss
- ❑ Cold extremities
- ❑ Cold sweats
- ❑ Night sweats
- ❑ Slow movements
- ❑ Slow speech
- ❑ Pins & needles
- ❑ Breathlessness
- ❑ Dizziness
- ❑ Palpitations
- ❑ Sensitivity to sun
- ❑ Lack of co-ordination especially of hands and feet
- ❑ Trembling
- ❑ Insomnia
- ❑ Loss of libido
- ❑ Repeated urinary tract infections
- ❑ Upper respiratory tract infections
- ❑ Pelvic Inflammatory Disease (PID)
- ❑ Poor response to treatments
- ❑ Candida
- ❑ Heavy eyelids
- ❑ Hoarse voice
- ❑ Goitre
- ❑ Muscle cramps
- ❑ Joint stiffness
- ❑ Heat/Cold intolerance
- ❑ Low basal temperature
- ❑ Exercise intolerance
- ❑ Salt craving
- ❑ Sweet craving
- ❑ Hypoglycaemia
- ❑ Fainting attacks
- ❑ Asthma
- ❑ Internal shivering

Puffiness of:
- ❑ Eyes
- ❑ Face
- ❑ Hands
- ❑ Feet
- ❑ Ankles

Mouth & Throat:
- ❑ Difficulty swallowing
- ❑ Sore throats
- ❑ Swollen tongue
- ❑ Choking fits
- ❑ Dry mouth
- ❑ Halitosis (bad breath)

Hearing Problems:
- ❑ Oversensitive hearing
- ❑ Noises in ears (hissing)
- ❑ Deafness

Hair:
- ❑ Body hair loss
- ❑ Head hair loss
- ❑ Brittle hair
- ❑ Eyebrow loss (outer third)
- ❑ Eyelash loss

Nails:
- ❑ Brittleness
- ❑ Flaking

Skin:
- ❑ Dry
- ❑ Flaky
- ❑ Coarse patches
- ❑ Sallow in colour
- ❑ Pallor
- ❑ Dark rings under eyes
- ❑ Pigmentation in skin creases
- ❑ Rashes & dermographia (wheals)

Numbness & Tingling in:
- ❑ Legs
- ❑ Feet
- ❑ Arms
- ❑ Hands
- ❑ Back
- ❑ Face

Pain:
- ❑ Migraines
- ❑ Pressure headaches
- ❑ Back and loin pain
- ❑ Wrist pain
- ❑ Muscle and joint pain
- ❑ Carpal Tunnel Syndrome

Digestive Problems:
- ❑ Loss of appetite
- ❑ Food allergy/sensitivity
- ❑ Alcohol intolerance
- ❑ Constipation
- ❑ Haemorrhoids
- ❑ Irritable Bowel Syndrome (IBS)
- ❑ Abdominal distension/flatulence

Blood Pressure & Pulse:
- ❑ High blood pressure
- ❑ Low blood pressure
- ❑ Slow/weak pulse (under 60 bpm)
- ❑ Fast pulse (over 90 bpm at rest)

Menstrual disorders:
- ❑ Cessation of periods (amenorrhoea)
- ❑ Scanty periods (oligomenorrhoea)
- ❑ Heavy periods (menorrhagia)
- ❑ Infertility
- ❑ PMS (premenstrual tension)

Visual disturbances:
- ❑ Poor focussing
- ❑ Double vision
- ❑ Dry eyes
- ❑ Gritty eyes
- ❑ Blurred vision

MENTAL

- ❑ Panic attacks
- ❑ Memory loss & confusion
- ❑ Mental sluggishness
- ❑ Poor concentration
- ❑ Noises and voices in head
- ❑ Hallucinations
- ❑ Phobias
- ❑ Loss of drive
- ❑ Post Natal Depression
- ❑ Nightmares

EMOTIONAL

- ❑ Easily upset
- ❑ Wanting to be solitary
- ❑ Mood swings
- ❑ Depression
- ❑ Nervousness/anxiety
- ❑ Personality changes
- ❑ Feelings of resentment
- ❑ Lack of confidence

ANY OTHER SYMPTOMS

Blood test history: (Please complete as far as you can. Any results should include reference range.)

Please attach copies of any laboratory tests you have.

TEST	Date	Result	Reference Range

Please attach copies of any other laboratory test results, for example, hair analysis, stool analysis etc.

Do you have any yeast or Candida infections, e.g., athlete's foot, skin rashes, nail infections?

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Please give an example of your daily diet:

Breakfast:……

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Lunch:……..

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Dinner: ……

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Snacks: ……

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Drinks (including alcohol): ……

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Vitamin and mineral supplementation:

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Do you have any food cravings? (please specify)

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Which foods do you hate and therefore avoid eating? (NOT due to allergy or intolerance)

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Which particular food and drink do you consume the most of every single day?

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Are you aware of any food allergies or intolerances?

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Do you have any intolerances to medication?

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Is there a family history of confirmed diagnosis of: (please tick and specify which relation, e.g. mother, paternal aunt, maternal grandfather, maternal cousin)

❑ **Thyroid disease** …… ❑ **ME/CFS** ……

❑ **Fibromyalgia** …… ❑ **Autoimmune disease** ……

❑ **Diabetes** …… ❑ **Arthritis** ……

❑ **Heart disease/Stroke** …… ❑ **Mental illness** ……

❑ **Other (please specify):** ……

Any comments about family history: ……

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Have you been diagnosed with:

❑ **Thyroid disease** ❑ **ME/CFS** ❑ **Fibromyalgia** ❑ **Autoimmune disease**

❑ **Diabetes** ❑ **Heart disease/Stroke** ❑ **Mental illness** ❑ **Arthritis** ❑ **Other**

Please specify: (eg Hashimoto's, Hypothyroidism, Lyme's Disease)……

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Date medical advice first sought: (approx) …… Age:……

Date diagnosed: (approx)…… **Age**:…..……

Date symptoms began: (approx)……..… **Age:**……..……

Was private advice sought: ❑ **Yes** ❑ **No**

Reasons/Details: ……..…

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Personal history of other illnesses before diagnosis: **(please give ages where possible)**

❑ **Glandular fever** ❑ **Severe viral infection (eg Flu)** ❑ **Diabetes**

Any other illnesses: .....……..…

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Details/Comments:……..…..…

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Did you experience any major life events before diagnosis - mental or physical trauma, surgery etc:
(please give ages where possible)

❑ **Hysterectomy** ❑ **Neck injury/Whiplash** ❑ **Tonsillectomy** ❑ **Cholecystectomy**

❑ **Traumatic pregnancy/Birth** ❑ **Severe accident** ❑ **Divorce** ❑ **Bereavement**

Any other events:…...……..……....

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Details/Comments:.....……..…

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Have you ever lived in a fluoridated water supply area: ❑ **Yes** ❑ **No**

Dates: (approx) ...……..……

Districts: **…**……..……

Have you had exposure to other environmental hazards: ❑ **Yes** ❑ **No**

Dates/Details: ……...…

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Have you experienced long-term exposure to electromagnetic fields (living near power lines, working with electrical machinery etc): ❑ **Yes** ❑ **No**

Dates/Details: ……...…

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If you have been diagnosed with thyroid disease and/or low adrenal reserve, or been given a trial treatment of thyroid hormone and/or adrenal support:

Date first diagnosed: (approx)…….……**Age**:.……

Past average basal temperature (if any): ……

Past average basal pulse rate (if any): ……...…

Now give a history of your treatment to include the medication and the dosages.

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Now give your present treatment, including supplements.

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As the following readings are important as an indication of your present metabolic status, would you please ensure you do them. Please take your basal temperature in the morning – immediately on waking and before getting out of bed – 3 minutes in the mouth. Ladies only do this during your period. Pulse rate – bpm – number of beats per minute.

Present average basal temperature: (eg 36.5 C)

Day 1 ……... **Day 2** ……... **Day 3** ……... **Day 4** ……... **Day 5** ……...

Present average basal pulse rate: (eg 72 bpm)

Day 1 ……... **Day 2** ……... **Day 3** ……... **Day 4** ……... **Day 5** …….

Any other comments about your past or present treatment or health:

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