Health Survey

Name:______________________________

Age:________________________________

Email:______________________________

Phone:______________________________

Biometrics:

Do you have children between the ages of :

1 and 12 years?	Yes/No
13 and 18 years?	Yes/No

What is your height?	________	metres
What is your weight?	________	kilos.
What is your waist circumference (at the navel)?	________	cm.

Lifestyle:

On average, how many servings of fruit and vegetables do you eat each day?

0-1 ___ 2-4 ___ 5 or more _____

On average, how many servings of milk, yoghurt and cheese do you have each day?

0-1 _____ 2 _____ 3 or more _____

Do you eat two or more servings of fish each week?

Yes No

How many servings of high fibre whole grains (wheat bread, cereal, brown rice or a fibre bar) do you each per day?

0 __ 1-2 __ 3 or more ___

Alcohol (units per week): ____________________

Water (glasses a day): ________________________

Sweets & Cakes (per week): _______________________

Do you smoke?

I have never smoked _____
I used to smoke, but I don't now ______
Yes, I currently smoke _____

How would you rate your energy levels?

1. wake up with no energy
2. wake up OK but experience a lull middle of the day
3. tired after dinner in the evening
4. tired all the time

How well do you sleep?

1. sleep well: *every night/mostly/sporadically/never*
2. difficulty falling asleep: Yes No
3. wake regularly at specific times_________________________
4. go to bed at __________ wake up at _____________

Stress Levels: work (L) 1 2 3 4 5 (H) home (L) 1 2 3 4 5 (H)

Do you live or work in a large metropolitan city that is often smoggy or heavily polluted?

Yes No

Do you exercise at least 3 times per week for at least 30 minutes each time? ***(includes walking, cycling or ore vigorous sports)***

Yes No

Are you an athlete who exercises/trains strenuously almost every day?

Yes No

On average, how much time do you spend in direct sunlight each day?

Less than 15 mins ___
15-30 mins ___
More than 30 mins ____

Do you find it relatively difficult to break old lifestyle habits and form new ones?

Yes No

Do you currently take supplements?

Yes No If Yes, what brand: ________________

Health History:

Has anyone in your immediate family been diagnosed with heart disease or suffered a heart attack prior to age 65?

Yes
No
I don't know

Do you have a family history of high blood pressure, or has anyone in your immediate family suffered a stroke?

Yes
No
I don't know

Has anyone in your immediate family been diagnosed with osteoporosis or suffered a hip fracture?

Yes
No
I don't know

Has anyone in your immediate family been diagnosed with cataracts or macular degeneration?

Yes
No
I don't know

Do you catch frequent colds or flu?

Yes No

Do you suffer from chronic joint pain, or have you been diagnosed with osteoarthritis?

Yes No

Do you suffer from swollen joints or have you been diagnosed with rheumatoid arthritis?

Yes No

If you are male, have you been diagnosed with an enlarged prostate or another prostate condition?

Yes No

If you are female, do you experience PMS or menopausal symptoms (such as hot flushes)?

Yes No

Do you frequently feel tired and run down?

Yes No

Do you often feel shaky or light-headed between meals (for example, an hour or two after breakfast)?

Yes No

Do you have patches of dry, itchy, red skin or have you been diagnosed with eczema?

Yes No

How would you rate your skin:

1. acne: Yes No
2. prone to breakouts: Yes No If so where exactly do they appear?________
3. dull: Yes No
4. generally clear: Yes No
5. mainly oily: Yes No
6. dry: Yes No
7. very good: Yes No

Do you suffer from asthma, frequent allergies or hay fever?

Yes No

Do you or any of your immediate family suffer from Diabetes Type 1 or Type

Yes No

Are you concerned about maintaining acute memory?

Yes No

Are you currently being treated by a doctor for any active health condition?

Yes No

If yes, please describe:

____

____

____

Has your doctor told you that you have kidney failure?

Yes No