NUTRITION AND ALLERGY CLINIC.

11 Mauldeth Close, Heaton Mersey, Stockport, SK4 3NP

Name Mr./Mrs./Ms/Miss _____

Address_____

_____

Tel.No. home_____ **work**_____

Occupation _____ **date of birth**_____ **Gender** _____

Any health problems

_____

_____

_____

_____

_____

What is your height? _____ **What is your weight?**_____

What is your normal blood pressure, if you know?_____

List any serious illnesses in your close family:

_____

_____

_____

Do you have regular exercise? _____

Do you avoid food containing additives? _____

Do you wash or peel fruit and vegetables before eating them? _____

Do you eat much raw food? _____

When did you last have antibiotics? _____

Please underline, wherever the answer is yes:

Are you pregnant?

Do you take the Pill?

Are you on HRT?

Do you have premenstrual problems?

Do you have hayfever?

Do you crave certain foods?

Do you grind your teeth?

Do you have burning feet?

Do you have thrush?

Do you have aches and pains?

Do you have arthritis?

Do you have irritable bowel syndrome?

Do you have M.E or Chronic Fatigue Syndrome?

Do you eat a lot of tomatoes, peppers, peaches, apples, or apricots?

Do you drink more than a glass of alcohol a day?

Do you drink more than a glass of milk a day?

Are you vegetarian?

Are you vegan?

Do you have any silvery grey or gold dental fillings?

Do your gums bleed?

Do you bruise easily?

Do you sleep badly?

Are you sensitive to chemicals?

Do you often drink apple or tomato juice?

Do you eat wheat, rye, oats or barley more than once a day?

Do you have white spots on your finger nails?

Do you fail to remember your dreams?

Do you have asthma?

Do you eat much red meat, yeast, or oily fish?

Are you sensitive to bright lights?

Are your eyes bloodshot, burning, or gritty?

Do you ever have migraine?

Do you drink squash or sodas?

Do you use tapwater for drinking, or making drinks?

Do you use aluminium saucepans?

Do you eat sweets or chocolate?

Do you have nose bleeds?

Do you have varicose veins?

Do you eat much instant food?

Do you drink much tea and coffee?

Do you feel unwell after 6 hours without food?

Do you ever have fits?

Are you planning to have a baby?

Do you often have diarrhoea?

Are you overweight?

Do you smoke?

Do you often feel depressed?

Are you anorexic?

Are you hyperactive?

Have you eaten much liver?

Do you binge?

Are you autistic?

Do you have eczema?

Are you addicted to anything?

Do you have allergies?

Do you often have infections?

Are you short of energy?

Do you use much sugar?

Do you use sweeteners?

Do you have water retention?

Is there cancer in your family?

Is there heart disease in your family?

Have you had any operations?

Do you take any prescription or over the counter drugs?

Do you have acne?

Do you have constipation?

Do you have prematurely greying hair?

Are you often thirsty?

Do you have heavy periods?

Do you have muscle twitches?

Do you have sore knees?

Are you post-menopausal?

Do you eat a lot of salt?

Do you eat a lot of fried food?

Have you ever taken cod liver oil?

Do you have hiccups?

Write down two days' typical intake of food, drinks, snacks, medicines, vitamins, minerals, evening primrose, or other supplements:

Day 1:

Breakfast:

Lunch:

Supper:

Bedtime:

Snacks:

Drinks:

Day 2:

Breakfast:

Lunch:

Supper:

Bedtime:

Snacks:

Drinks:

(signed)_____ _____