Health Questionnaire

Please answer the below questions to help me have a better understanding of your health and needs.

Date:

Name:

Date of birth:

Medical History

1. Please tick if you have or have had any of the following conditions
    - Diabetes
    - High blood pressure
    - High cholesterol
    - Heart disease
    - Stroke
    - Thyroid disease
    - Asthma
    - Depression/anxiety
    - Sleep apnoea
    - Coeliac disease
    - Irritable Bowel Syndrome
    - Cancer
    - Other- please specify

2. Please list all medications you are taking:……
   ……
   ……
   ……

3. Please list all vitamins and minerals or other supplements you are taking:……
   ……
   ……

4. Do you have any food allergies or intolerances?.....
   ……
   ……

5. Are there any foods you are avoiding? .....
   ……
   ……