

YOUR PERSONAL HEALTH AND DIET REPORT

Page 1:

Your Name, Address, Basic Details

Title (Mr, Ms etc.)	<input type="text"/>
First Name	<input type="text"/>
Last Name	<input type="text"/>
e-Mail Address	<input type="text"/>
Address1	<input type="text"/>
Address2	<input type="text"/>
Town	<input type="text"/>
County	<input type="text"/>
Postcode	<input type="text"/>
Country	<input type="text"/>
Date of Birth	<input type="text"/>
Your Gender	<input type="text" value="Select"/>
Weight	<input type="text"/>
Height	<input type="text"/>
What kind of work do you do?	<input type="text"/>

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Once submitted, this information will be seen only by Linda Lazarides for the purpose of preparing your personal health and diet report. Your information will never be passed on to any third party.

THIS PDF VERSION OF THE QUESTIONNAIRE IS FOR INFORMATION ONLY. PLEASE DO NOT TRY TO SUBMIT IT TO LINDA LAZARIDES. THE QUESTIONNAIRE YOU NEED TO COMPLETE IS ONLINE VIA A LINK WHICH WILL BE MADE AVAILABLE TO YOU ONCE YOU HAVE SIGNED UP FOR YOUR PROGRAMME. YOU CAN SIGN UP BY CLICKING THE BUTTON AT <http://www.health-diets.net/lindalazarides/consultations.html>

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Questions For Women Only

Number of Children

No. of Miscarriages
(if applicable)

Use of Contraceptive Pill

Are You Pregnant?

Yes

No

If so, how many weeks?

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Your Health Past And Present

Please give details of any significant past health problems. Please list all past or present medications you have been prescribed, any current health or weight problems you would like help with, and the length of time you have had each problem.

Significant Past Health Problems

Medications Taken
& approximate year prescribed

Current Health Problem 1

Current Health Problem 2

Current Health Problem 3

Current Health Problem 4

Current Health Problem 5

Current Health Problem 6

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Your Doctor's Comments

On this page I need to know any significant comments that your doctor has made, any test results, and details of anything that seems to help or worsen your condition

Have you consulted a doctor?
about your current health problems

Yes
 No

Doctor's comments
and results of tests (if any)

What helps or worsens
these problems?

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Your Symptoms

Please check (tick) any persistent symptoms which seem particularly to apply to you in recent times

Eyes

- Much harder to focus in dim light
- Eyelids itchy, red
- Eyes often feel dry

Ears

- Persistent itching in ears
- Deafness
- Ringing sounds inside ears

Skin, Hair, Nails, Mouth

- Spotty skin
- Dry flaky skin
- Persistent dandruff
- Puffy skin
- Water retention
- Itchy red patches
- Eczema or dermatitis
- Sore, raw tongue
- Yellowish skin or eyes
- Cracked lips
- Sores that won't heal
- Split or brittle fingernails
- White-spotted fingernails
- White fingernail beds
- Burning feet

Immune System

- Frequent colds or infections
- Persistent thrush (yeast infections) in mouth or vagina

Muscles

- Cramps
- Spasms
- Pain
- Muscles knotted, won't relax

Circulation

- Irregular heartbeats
- Palpitations
- Sensitive to cold
- Easily get too hot
- Easy bruising
- High cholesterol
- High blood pressure

Hormones (women)

- Premenstrual symptoms
- Premenstrual mood changes
- Painful menstrual periods
- Heavy menstrual periods

Hormones (men)

- Absence of menstrual periods
- Breast tenderness
- Hot flushes
- Painful intercourse

Hormones (men, women, children)

- Prostate problems
- Breast development
- Fainting, dizziness or headaches if you miss a meal
- Unexplained weight gain
- Dark colour under eyes
- Always thirsty
- Frequent urination

Airways

- Breathlessness
- Congested sinuses
- Nose always runny or stuffy
- Chronic catarrh
- Poor sense of taste or smell
- Wheezing

Your Symptoms (cont'd)

Please check (tick) any persistent symptoms which seem particularly to apply to you in recent times

Brain & Nervous System

- Spaced out or 'unconnected' feeling
- Deteriorating co-ordination
- Deteriorating memory
- Increasing confusion
- Mood swings
- Poor concentration
- Tremors
- Easily startled
- Nervousness and anxiety
- Panic attacks
- Insomnia
- Depression
- Irritability
- Psychiatric problems
- Hyperactivity

Bones & Joints

- Bone pain or tenderness
- Joint pain, swelling or tenderness
- Bone brittleness (osteoporosis)

Digestion

- Poor appetite
- Bowel motions less than once a day
- Chronic diarrhoea
- Chronic constipation alternating with diarrhoea
- Gall bladder problems
- Gripping tummy pains with or without mucus discharge
- Frequent bloating
- Discomfort in tummy after eating
- Heartburn
- Intestinal flatulence
- Frequent belching
- Much undigested food in your stools
- Anus always itchy
- Often feel nauseous

Liver

- Easy exhaustion
- Unexplained daytime drowsiness
- Head feels 'foggy'
- Frequent headaches
- Water retention
- Psoriasis
- Dark colour under eyes

- Great lethargy
- Bad reactions to chemicals
- Feeling unwell after coffee or small amount of alcohol
- Tenderness under right-hand ribs
- Have you ever had a cyst or tumour of the breast or uterus?
- Have you ever been diagnosed with fibroids or endometriosis?
- Chronic slight headache or 'hung-over' feeling without drinking alcohol
- Bad reactions to chemicals

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Your Environment

Do you smoke?
If so, how many a day?

Is there a heavy smoker in your home?
 Yes
 No

How many silver (amalgam) fillings do you have in your teeth?

List any chemicals you work with e.g. dry cleaning fluids, paint, varnish, solvents, sheep dip

Do you live or work near a source of pollution? e.g. factory with emissions, fields sprayed with pesticide
 Yes
 No

Do you work in a sealed building?
 Yes
 No

Have you ever abused drugs or alcohol?
 Yes
 No

List any over-the-counter medicines you use regularly

Do you have any new carpets or soft furnishings?
 Yes
 No

Do you regularly use fly spray or pesticide in home or garden?
 Yes
 No

Is your home scented with artificial air fresheners?
 Yes
 No

Does your home suffer from mould (mold) and/or dampness?
 Yes
 No

Please use this box to elaborate on any of the above

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Your Eating Habits

You must be truthful in the next two sections. If you give me wrong information I may not be able to give you the most helpful advice

How many times a day do you eat or drink something sweetened with sugar?

How many teaspoons of sugar do you add to each cup of tea, coffee or other drinks?

How many times a day do you consume artificial sweeteners (including

How many alcoholic drinks do you consume per week?

How many cups of coffee do you drink per day?

How many glasses of water do you drink per day?

How often do you add salt to food, even if it is already salted?

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Nearly there, only three more pages to go...

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Your Meals

Please describe what you normally eat for breakfast

Please describe what you normally eat for lunch

Please describe what you normally eat for dinner

Please list your favourite snacks and drinks and how often you consume them

Please list any foods you particularly dislike

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If You're Trying To Lose Weight

Why do you think you have a weight problem?

- I have food addictions
- I drink too much alcohol
- I am exposed to too much temptation
- I don't get enough exercise
- I seem to have a very slow metabolism
- I have been overeating since a traumatic event
- I overeat because I am bored and discontented
- Dieting is such a losing battle I've given up trying
- I eat to comfort myself because I hate my body
- I believe I may have water retention

Please use this box to elaborate on any of the above

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Additional Information

Please list any treatments you have already tried, both orthodox and alternative/complementary, and the results they achieved

Please list any supplements, herbs or other products you are currently taking, and dosage per day

Any other information, comments or insights, e.g. known food allergies or other special medical circumstances which need to be considered when constructing a diet for you

Today's Date

Security Code

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By submitting this questionnaire, you certify that you accept and understand Linda Lazarides' [Terms & Conditions](#). Also that the information you have submitted is to the best of your knowledge true and correct and includes everything which could reasonably be considered relevant to the supply of your personal Health & Diet Programme.

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