Health and Lifestyle Questionnaire – Females

Name:	Title:
Address:	Date of Birth:
	Daytime tel:
	Evening tel:
	Email:

1. Have you been diagnosed as suffering from heart disease, stroke or any other disease of the circulation? *YES/NO*
   If yes please give details:

2. Have you been diagnosed as suffering from any illness that may affect the ability of your blood to clot? *YES/NO*
   If yes please give details:

3. Have you been diagnosed as having diabetes? *YES/NO*

4. Do you suffer from any other illness? *YES/NO*
   If yes please give details:

5. Are you currently on any long-term medication? *YES/NO*
   If yes please give details:

6. Do you smoke? *YES/NO*
   If yes - how many and what brand?

7. Do you drink alcohol? *YES/NO*
   If yes approx how many units per week do you drink?

8. Do you take any form of dietary supplement e.g. fish oils, vitamins or minerals? *YES/NO*
   If yes please give details:

9. Are you currently on a weight reducing or other diets? *YES/NO*
   If yes please give details:

10. Do you have any food allergies? *YES/NO*
    If yes, please give details:

11. Do you exercise regularly or take part in team sports? *YES/NO*
    If yes, which form of exercise and how often?

12. Are you premenopausal, perimenopausal, or postmenopausal?

13. If premenopausal, are you currently taking the oral contraceptive pill? *YES/NO*
    If yes, what type?

14. If premenopausal, are you planning a pregnancy in the next 3 months, currently lactating, or have you given birth in the past 6 months? *YES/NO*

15. If peri or postmenopausal, are you currently on HRT? *YES/NO*

16. Have you been involved in a clinical trial in the last 3 months? *YES/NO*
    If yes please give details:

Thank-you for completing this questionnaire

Health and Lifestyle Questionnaire - Males

Name:	Title:
Address:	Date of Birth:
	Daytime tel:
	Evening tel:
	Email:

1. Have you been diagnosed as suffering from heart disease, stroke or any other disease of the circulation? *YES/NO*
   If yes please give details:

2. Have you been diagnosed as suffering from any illness that may affect the ability of your blood to clot? *YES/NO*
   If yes please give details:

3. Have you been diagnosed as having diabetes? *YES/NO*

4. Do you suffer from any other illness? *YES/NO*
   If yes please give details:

5. Are you currently on any long-term medication? *YES/NO*
   If yes please give details:

6. Do you smoke? *YES/NO*
   If yes how many and what brand?

7. Do you drink alcohol? *YES/NO*
   If yes approx how many units per week do you drink?

8. Do you take any form of dietary supplement e.g. fish oils, vitamins or minerals? *YES/NO*
   If yes please give details:

9. Are you currently on a weight reducing or other diets? *YES/NO*
   If yes please give details:

10. Do you have any food allergies? *YES/NO*
    If yes, please give details:

11. Do you exercise regularly or take part in team sports? *YES/NO*
    If yes, which form of exercise and how often?

12. Have you been involved in a clinical trial in the last 3 months? *YES/NO*
    If yes please give details:

Thank-you for completing this questionnaire