Nutrition Medicine at Hartgood

Preliminary Questionnaire

All details are treated with the strictest confidentiality.

Practitioner: ***Hartmut Michael Günther****, B.Sc. Hons (Biochemistry & Genetics, La Trobe University) Graduate Diploma Nutrition Medicine with Distinction (RMIT), Graduate Diploma Psychology (Monash University)*

Contact Hartmut directly for any questions:
Mob: 0439 54 7788, Email: hart@hartgood.com | www.hartgood.com

Please **take your time** and complete this questionnaire and email back to Hartmut at – hart@hartgood.com

Once completed, this document (along with your blood test results and MSQ) is easily updated, saving time and money while avoiding unnecessary repetition and duplication. This document then becomes a valuable resource and you can use it when seeing ANY doctor or specialist or health practitioner for any reason – it will guarantee greater quality health care and save you time, money and frustration. Make the effort. It's worth it.

Your Details

Your Name & Age:

Your Gender:

Phone:

Email:

What do YOU want to get out of this assessment and consultation and treatment?

Keep it simple and use your OWN words. The more clarity and self declaration you can garner here, the more likelihood it will happen.

Fill in as much as you can.

We will speak about your main presenting health issues and what is not filled-in here during the online or in-clinic consultation.

Any diagnosed illnesses, either now or in the past

Diagnosed illnesses or chronic conditions, either now or in the past	Date when Started	Duration (In days, weeks, months or years)

All operations, accidents and other major life events

List those that can be remembered or had complications here.

Allergies or food intolerances

Any allergies to foods, chemicals, medications, pollen etc:	Date when Started	Duration (In days, weeks, months or years)

Medications

List any Medications being taken now. Please include medications taken previously in the last year. Please ensure spelling of drug is correct. We check for side effects.

If you already have a list of Medications from your GP or Pharmacist, can include that instead

List any Medications being taken along with the **reason for taking it** (drugs these days can be prescribed for multiple reasons)	Date when Started	Date when Finished	DOSE

Add more rows if needed

Supplements

List any supplements (Vitamins, minerals, herbs etc) being taken. **Alternatively, you can attach/include pictures of the label/ingredients.**

List any supplements	Date when Started	Duration (In days, weeks, months or years)	DOSE

Add more rows if needed

Life-stage factors, Sleep & Exercise

How much do you **walk** during the week (in minutes)?

Any other **exercise** and for how long and on how many days:

How many hours **sleep**/night on average:

Is sleep restful and do you wake refreshed:

How many **coffees** consumed/day on average:

How many standard **alcohol** drinks consumed per day on average:

How many **alcohol-free days** per week:

Water – where from and what is in it (i.e. chlorine/fluoride etc):

How much **water consumed/day**:

How many **Bowel motions** per day on the average:

Colour of **urine** on average:

If working, how many hours perweek:

What is your main activity during day:

Do you **smoke**:

Chemical, allergen, toxin and stress exposures (Home and Work)

Stress level at home (none – minimal – moderate - high):

Stress level at work (none – minimal – moderate - high):

Any **pets or animals** at home or work:

Are chemicals contained in your **personal care products**?

Are chemicals contained in **cleaning products** around house?

Are you exposed to **chemicals** at work or outside home

If so what are they:

What **water** do you drink? (Tank, Town, Bore etc)

Are any **pollution levels** near home or work noticeable?

Do you frequently use and/or interact with **plastic products**?

Do you have **dental amalgams (silver colour)** and how many?

Any other toxin exposures you know of:

Genetics and Family illness history

Any cases of chronic or severe illness in your family history like diabetes, heart disease, high blood pressure, obesity etc (indicate whether mother, father, grandparents, siblings, children etc):

What are you eating

We don’t need a food dairy – just an idea of what you are putting in your mouth during the day. Please **indicate 3 alternative options** that you normally have for –

Breakfast

Lunch

Dinner

+ Snacks

+ Drinks

WOMEN ONLY - GYNAECOLOGIC HEALTH

Only answer what is relevant.

Age of **menstruation** onset:

How many days between periods:

Duration of period flow:

Are periods regular:

If irregular state how so:

Has flow duration changed recently:

Have you taken or are you on the **contraceptive pill**:

If so, when and for how long.:

Any other form of contraception:

Have you had any miscarriages,

When was your last PAP Smear?:

Have you had a **Bone density study**:

Pre-menstrual Tension

Following is a list of symptoms commonly occurring in the premenstrual period, i.e. 1 to 14 days before the period is due. Please indicate if symptoms are mild, moderate or severe Leave blank if absent.

PMT-A

Tension:

Anxiety:

Irritability:

Mood Swings:

PMT-C

Increased appetite:

Sweet-craving:

Easily tired:

Headache:

PMT-D

Confusion:

Forgetfulness:

Constipation:

Acne increased:

Migraine:

Depression:

PMT-H

Weight gain:

Face swelling:

Ankle swelling:

Breast enlargement:

Breast tenderness:

Childbirth/Natal History

Number of children:

In any pregnancy, did you have any of the following - Stating mild/moderate/severe

Morning Sickness:

Excess Weight Gain:

Vomiting:

Ankle swelling:

Postnatal Depression:

High Blood Pressure:

Complications of any sort:

Did you breastfeed, and if so, state how long:

Menopausal History

At what age did your periods stop:

Did you have any period problems around this time:

Do you currently suffer from hot flushes:

Leg cramps at night:

Dull ache in your bones:

Are you on hormone therapy, if so, please describe :