PATIENT QUESTIONNAIRES: WEIGHT, NUTRITION AND MICRONUTRIENTS

When a person is concerned about their personal wellbeing, quality of life and focus their life around prevention of disease, they may be interested in micronutrients and their impact on their health. Nutrition and our micronutrient requirements are different at age 30 as compared to age 40, 50, and beyond. Absorption difficulties, especially vitamin B12, quite commonly occur as we age. Lack or excessive physical activity, poor nutrition, prescription drugs, smoking, and alcohol, ALL IMPACT MICRONUTRIENT DEMANDS. If a person is wondering if nutrition may have an impact on the problems being experienced, and is interested in knowing if this is an issue that needs to be addressed, it is important to routinely ask yourself questions that allow you to know specifically what is going on.

The Weight, Nutrition and Micronutrient Questionnaire will help you identify if you are at risk of having issues with your nutrition and biochemical individuality. It may also point to issues with absorption, celiac disease, and gallbladder disease. Chronic illnesses such as chronic fatigue, fibromyalgia, arthritis, cancer, diabetes, and cardiovascular disease and osteoporosis, to name a few can be affected, directly or indirectly, by micronutrient deficiencies. Vitamin, mineral and antioxidant deficiencies have been shown to suppress the immune system which can lead to inflammation, and decreased immunity.

This questionnaire is based on your subjective symptoms. To help determine whether you are getting enough of these nutrients from your diet, answer the questions below. Please remember that this questionnaire only examines your risk of micronutrient deficiency based on symptoms, it is not a replacement for a healthcare professional. By filling this questionnaire out, you can then address the concerns with your doctor and you may have a more specific conversation regarding your health and healthy aging.

QUESTIONS:

1. What is your age?   Years: _____________
2. Are you Male or Female?  ___________________
3. Are you a woman 14 to 50 years of age? Yes   No
4. Are you 50 years of age or older? Yes    No
5. Are you pregnant or trying to get pregnant? Yes No
6. Are you vegetarian or vegan? Yes   No
7. What is your ethnicity? ___________________
8. How tall are you?   Feet/inches: ________ or cm: ________
9. How much do you weigh?   Pounds (lbs): ________ or Kg: ________
10. What is your Body Mass Index? ____________________  * At the end of the document- see how to calculate
11. Are you a current smoker? Yes   No
12. Do you drink alcohol?   Yes   No  (Beer   Wine   Hard Liquor)
13. On average, do you drink 3 or more units each day? Yes   No  (Beer   Wine   Hard Liquor)
14. Do you consider yourself to be overweight? Yes   No  (BMI: ________)  * See below on how to calculate
15. Do you consider yourself to be under weight? Yes   No  (BMI: ________)  * See below on how to calculate
16. Would you like to? Lose weight Maintain weight Gain weight
17. Do you have an active lifestyle? (Example: 30 minutes of activity 5 times per week - housework, gardening, walking, running etc.) Yes No
18. Describe the environment where you spend most of your time (air quality, light quality, etc.). How healthy do you consider it on a scale of: 0- very unhealthy, 10-super healthy ________________
19. Describe any special diet you are currently following. ____________________________
20. Do you avoid milk or dairy products without eating other calcium-rich foods? Yes No
21. Do you take supplements? Yes No (Make sure to let your health care professional know about all the supplements you take - Bring them to your first visit)
22. When the weather is nice, how often do you spend at least 10 minutes a day in full sun without sunscreen? Daily 3-5 times a week 1-3 times a week Not on a regular basis Never
23. Do you miss out on sunlight through being house bound, avoiding the sun, always cover your skin or always wearing sun cream? Yes No
24. Do you frequently take aspirin, antacids or any other non-prescription medicines ____________________________ - Bring them to your first visit
25. Do you frequently take other prescription medicines? ____________________________ - Bring them to your first visit
26. Please indicate how often you take the following actions to eat a healthy diet. (times per week):
   Eat breakfast _____________ Eat lunch _____________ Eat dinner / supper _____________
   Snack frequently ___________ Graze throughout the day ___________ Have a late night snack ___________
   Have deep fried foods ___________ Eat when stressed ___________ Eat when bored ___________
   Avoid GLUTEN ___________ Avoid milk ___________ Avoid eggs ___________ Avoid other ___________
   Plan ahead when eating ___________ Read food labels carefully ___________
   Choose healthier substances ___________ Control portion size/avoid seconds ___________
27. When do you feel you would be ready to work on your diet/nutrition habits?
   Not an issue Not ready to change Willing to change soon Willing to change in the future
28. How often do you buy food from the outer aisles of the grocery store? (i.e., fresh or frozen fruits and vegetables, fresh meat or seafood, dairy, grains, and nuts from the bulk bins) All the time Often Sometimes Not at all
29. How often do you buy food from the center aisles of the grocery store? (i.e., foods that come in cans, bags, or boxes, such as crackers, canned soups, cereals, and frozen dinners) Not at all Sometimes Often All the time
30. How often do you eat out at restaurants? Not at all Sometimes Often All the time
31. How often do you eat out at fast-food restaurants? Not at all Sometimes Often All the time
32. What do you eat when you snack? ____________________________
33. How often do you eat fresh or frozen green vegetables, such as kale, collard greens, chard, or spinach? All the time Often Sometimes Not at all
34. How often do you eat fresh or frozen fruits and vegetables from at least 3 different color groups (e.g., red berries, purple eggplant, orange sweet potatoes, and green broccoli) all in one day? All the time Often Sometimes Not at all
35. What are your favorite fruits and vegetables? ____________________________
36. How often do you eat low-fat dairy products such as yogurt or cheese, soy, or rice-milk products? **All the time**, **Often**, **Sometimes**, **Not at all**

37. How often do you eat fish, such as sardines, salmon, trout, and tilapia? **All the time**, **Often**, **Sometimes**, **Not at all**

38. How often do you eat red meat, such as beef, mutton, lamb, goat, and game meats (e.g., rabbit, venison, buffalo)? **Not at all**, **Sometimes**, **Often**, **All the time**

39. How often do you eat other meats, such as chicken, turkey, pork, and game birds (e.g., pheasant, quail)? **All the time**, **Often**, **Sometimes**, **Not at all**

40. How often do you eat processed meats, such as bacon, sausage, hot dogs, and bologna? **Not at all**, **Sometimes**, **Often**, **All the time**

41. How often do you eat fried, canned, or smoked meats? **Not at all**, **Sometimes**, **Often**, **All the time**

42. How much **salt** do you use? 
   - *Do not add salt at the table*
   - *Sparingly, use on a few foods*
   - *moderately, use on some foods*
   - *consider myself a heavy salt user*

43. How much **sugar** do you use? 
   - *None, little or no artificial sweeteners*
   - *Use only artificial sweeteners*
   - *Occasionally use sugar or eat sweets*
   - *I consider myself a heavy sugar user*
   - *Use sugar every day (in coffee, on cereal)*
   - *I have a sweet dessert or snack daily*

44. How many **beverages containing caffeine** do you drink in a day? (For example: coffee, tea, cocoa, and many soft drinks)? 
   - *None*
   - *1 - 2 / 8 oz. servings*
   - *3 - 5 / 8 oz. servings*
   - *6 - 10 / 8 oz. servings*
   - *11+ / 8 oz. servings*

For the following questions, please answer each question in the Yes / No format, and if possible in some questions you may want to define a scale with a score of 10 to 0; grade 10- if you have a significant issue and 0- if you don't have the issue at all.

1. Is your hair dry? _________ Is your hair brittle? _________ Is your hair dull or lifeless? _________
2. Is your hair oily? _________ Is your hair falling out? _________ Is your hair thin? _________
3. Is your hair prematurely grey? _______ Do you have cowlicks? _______ Do you have dandruff? _______
4. Does your hair grow slowly? _______ How bad would you consider your hair loss? _______
5. Do you have acne? ____________ Do you get pimples or blackheads, especially on your upper back or shoulders? ________________
6. Do you get hives? ___________ Do you get warts? _________________
7. Do you get shingles? __________
8. Do you have eczema or psoriasis? ________________
9. Do you get dermatitis or other skin rashes? ________________
10. Do you have rough, bumpy skin on the backs of your arms? __________
11. Do you have liver (brown) spots on your skin? _________________
12. Do you have little pink spots or broken capillaries on your skin? ________________
13. Do you perspire or sweat excessively? _________________
14. Do you feel cold and sweaty or get gooseflesh? ___________
15. Do you feel warm and flushed at normal temperatures? ___________
16. Is your skin warm, moist and fine textured? _________________
17. Is your skin greasy and scaly around your mouth, nose, or eyes? ______________
18. Is your skin oily or crusty on your nose, around your eyes, and/or forehead? ______________
19. Do you have dry or cracked skin behind your ears? ______________
20. Is your skin generally dry? ____________ Is your skin rough, flaky or scaly? _____ Is your skin itchy? ______________
21. Is your complexion sallow (pale grey/green/yellow tint)? ________________ Is your complexion pale? ___________
22. Do you have pale skin, especially on the palms of your hands? ________________
23. Do the soles of your feet and/or palm of your hands have a yellowish tint? ______________
24. Do you have white patches on your skin (vitiligo)? ____________ Do you have red or inflamed skin? ____________
25. Do you bruise easily? ____________ Is your skin aging rapidly? _______________
26. Do you have enlarged facial pores? ____________ Is your skin unusually sensitive to the sun? _______________
27. Do you have puffiness or bloating in your face, or under your eyes? ______________
28. Are your eyes sensitive to bright light (sunlight, glare, headlights, etc.)? _______________
29. Is your eyesight getting worse? ____________ Do you have poor night vision? ______________
30. Do you find it difficult to adjust your eyes to the light or when entering a dark room? ______________

Calculating your own BMI is very easy if you know your height and weight:

- Measure your height in meters (h) and multiply the figure by itself (square).
- Measure your weight (w) in kilograms and then Divide your weight by your height squared
- FORMULA: \( BMI = \frac{w}{h \times h} \)

**Notes for the Doctor:**