

GKNOWMIX HEALTH QUESTIONNAIRE

Name..... Referred by.....
 Ethnicity..... Date of birth..... Age..... Gender/Sex.....
 Contact Tel Numbers..... Email.....

Reason for testing:

Medical Condition	Patient (yes/no)	Age of Onset	Current medication of patient	Family Relationship (e.g. mother, brother)	Age of Onset
Anaemia / iron deficiency					
Angina / Coronary heart disease					
Alzheimer's disease					
Arthritis / Osteoarthritis					
Cancer (specify type):					
Chronic periodontitis					
Deep vein thrombosis					
Diabetes Type II					
High blood cholesterol					
High blood iron					
High blood pressure					
Hypothyroidism					
Metabolic syndrome					
Multiple Sclerosis					
Myocardial infarction					
Non-alcoholic fatty liver disease					
Osteoporosis					
Peripheral vascular disease					
Polycystic ovary syndrome					
Recurrent pregnancy loss					
Restless legs syndrome					
Sleep apnoea					
Sport injury (recurrent)					
Stress, Anxiety, Depression					
Stroke					
Other medication / diseases or Previous genetic test done					

PLEASE ALSO PROVIDE RELEVANT/AVAILABLE PATHOLOGY RESULTS (Lipid profile/cholesterol, homocysteine, glucose, ferritin levels, and histology/immunohistochemistry in the case of cancer patients), OR

APPROVAL TO REQUEST THIS INFORMATION FROM YOUR DOCTOR / LABORATORY YES NO

Patient Name.....

Referred by.....

Medication use and Reasons for Change if Relevant to Indication for Genetic Testing										
Treatment failure?										
Chronic medication taken previously										
Change of medication / dosage considered?										
Medication Side Effects (Please Specify)										
Anti-depressants (e.g. weight gain)			Y	N	Anti-retrovirals (e.g. weight gain, dyslipidaemia)			Y	N	
Cholesterol-lowering statins (e.g. muscle pains)			Y	N	Immunomodulating drugs (e.g. depression)			Y	N	
Other medication side effects (Please Specify):										
Did You Previously [P] or Currently Take:					Blood Pressure Medication:			Y	N	P
Oral Contraceptive Pill (OCP)?		Y	N	P	Systolic Blood Pressure		mmHg			
Hormone Replacement Therapy?		Y	N	P	Diastolic Blood Pressure		mmHg			
Blood/Nutrient deficiencies?		Y	N	P	Iron injections?		Vit B12 injections?			
Blood donor?		Y	N	P	Pregnant (females)?					
HOW MANY UNITS OF ALCOHOL DO YOU CONSUME ON AVERAGE PER WEEK?										
One unit of alcohol equals: 250 ml beer or larger, 1 glass (125 ml) of wine, 1 pub measure of spirits										
Abstain		1 – 2 units		1 – 13 units		14 – 21 units		22+ units		
Do you smoke?		Y	N	P	Tobacco/Other:					
Prolonged exposure to environmental toxins (e.g. agricultural pesticides, occupational solvents)								Y	N	
Weight	kg	Height	cm	Waist	cm	Hips	cm			
IN THE PAST 3 MONTHS, HOW MANY TIMES A WEEK HAVE YOU CONSUMED THE FOLLOWING FOODS										
(please underline foods taken or exclude those not relevant)										
[0] Never		[1] Once per week		[2] Twice per week		[3] Three times per week				
[4] Four times per week		[5] Five times per week		[6] Six times per week		[7] Every day				
Hamburgers, Pizza				All legumes (beans, peas, lentils)						
Red meat (e.g. beef, lamb, mutton)				Potatoes with skin						
Fried chicken / cooked chicken with skin				At least 5 portions fruits and vegetables (per day)						
Hot dogs / Sausages				Whole grain breads. cereals (low GI wheat, oats)						
Salad dressings (excludes 'Lite' versions)				Broccoli, cauliflower, mushrooms						
Butter and margarine (excluding pro-active versions)				Turnips, artichokes, asparagus						
Fried eggs (excludes cooking, boiling and baking)				Avocado, spinach						
Full cream milk and dairy products (fresh, sour or powdered)				Oranges, grapefruits (pure fruit versions)						
Fried hot potato chips, potato crisps, corn chips, popcorn				Organ meats (e.g. liver, kidney, giblets)						
Biscuits, cake, cookies, pastries				Fizzy drinks, tea/coffee with sugar						
Supplements taken			Daily:			Occasionally:				
Food allergy / intolerance:										
Are you following a specific style of eating? (e.g. Vegetarian, Banting)					Y	N	My Preference			
WHICH BEST DESCRIBES YOUR PHYSICAL ACTIVITY STATUS?										
(Includes walking, swimming, cycling, attending exercise classes, each lasting more than 30 minutes)										
Complete lack of exercise		Exercise once a week		Exercise 2 – 3 times/week		Exercise 4+ times/week				
Which best describes your occupational activity?										
Sedentary (e.g. desk work, driving)			Moderate (e.g. housework)			Physical labour (e.g. gardener)				