<p>| | | |</p>
<table>
<thead>
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</thead>
</table>
| 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

<table>
<thead>
<tr>
<th>Name:</th>
<th>Title:</th>
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<tbody>
<tr>
<td>Address:</td>
<td>Date of Birth:</td>
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<td>Daytime tel:</td>
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<td>Evening tel:</td>
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<td>Email:</td>
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</tbody>
</table>

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   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:

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**Thank-you for completing this questionnaire**