***NOTE FOR RESEARCHERS PREPARING A QUESTIONNAIRE:***

***RED = COMPULSORY QUESTIONS; BLACK = OPTIONAL (CAN BE AMENDED/REMOVED/ADDED TO SO THEY REFLECT YOUR INCLUSION/EXCLUSION CRITERIA)***

***INSERT STUDY NAME***

**Medical and Lifestyle Questionnaire**

|  |  |  |
| --- | --- | --- |
| Name: | | Title: |
| Address: | | Date of Birth: |
| Gender: |
| Daytime Telephone: | Evening Telephone: | Best time to call: |
| Weight (kg): | Height (m): | BMI (kg/m2): |
| E-mail:  Do you use emails on a regular basis? YES/NO | | |

How did you hear about the study? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Please mark as appropriate*

**Study requirements**

* Are you able to spend 4 full days (8am to 5pm) in the clinical unit? YES/NO
* Are you willing to provide stool samples at each visit? YES/NO
* Are you female YES/NO

*Please note that only female volunteers are eligible to participate in this study*

**Medical questions**

1. Have you been diagnosed as having any of the following?

a) High blood cholesterol YES/NO

b) High blood pressure YES/NO

c) Thyroid disorder YES/NO

d) Diabetes or other endocrine disorders YES/NO

e) Heart problems, stroke or any vascular disease in the past 12 months YES/NO

f) Inflammatory diseases (e.g. rheumatoid arthritis) YES/NO

h) Renal, gastrointestinal, respiratory or liver disease/disorder YES/NO

i) Cancer YES/NO

1. Have you been diagnosed as suffering from any other illness? YES/NO

*If ‘YES’, please give details*

1. Within the past 3 months, have you taken any medication (prescription or non-prescription)? YES/NO

*If ‘YES’, please provide:*

* *Name of medication(s)*
* *Reason(s) for use*
* *Dosage*
* *Frequency of use, e.g. daily, once every 2 weeks.*

1. Have you been diagnosed with an infectious disease, e.g. hepatitis B? YES/NO

*If ‘YES’, please give details*

1. Have you had any surgery within the past 3 months or do you have surgery planned? YES/NO

*If ‘YES’, please give details*

1. Have you ever suffered from a pulmonary embolism, deep vein thrombosis, blood clots or had a blood transfusion? YES/NO

*If ‘YES’, please give details*

1. Do you have a pacemaker? YES/NO
2. This question is **only to female** participants. (REMOVE Q8 IF NOT RECRUITING FEMALES)

|  |  |
| --- | --- |
| 🞎 |  |
| 🞎 |  |
| 🞎 |  |

1. Are you:

Premenopausal

Perimenopausal

Postmenopausal

*If you are premenopausal:*

1. Are you using contraception? YES/NO

*If ‘YES’, please give details (including the name of the contraceptive pill or device)*

1. Do you have regular menstrual cycles? YES/NO
2. Are you pregnant, lactating or planning a pregnancy in the next year? YES/NO

*If you are postmenopausal:*

1. Do you remember when your final menstrual cycle was?

|  |  |
| --- | --- |
| Less than 1 year ago | 🞎 |
| 1-2 years ago | 🞎 |
| 2-5 years ago | 🞎 |
| More than 5 years ago | 🞎 |
| Can’t remember | 🞎 |

1. Are you using hormone replacement therapy (HRT)? YES/NO

*If ‘YES’, how long have you been on HRT?*

**Lifestyle questions**

1. Are you currently taking part in or been involved in a clinical trial/research study within the last 3 months either here or elsewhere? YES/NO

*If ‘YES’, please give details:*

1. Have you been screened or contacted recently about taking part in a study here or elsewhere? YES/NO

*If ‘YES’, please give details*

1. Are you a blood donor? YES/NO *If ‘YES’, when was the last time you donated blood?*

*If you are eligible to participate in the study, are you willing to postpone* YES/NO

*further blood donations until 3 months after your final study visit?*

1. Do you have any food allergies (e.g. gluten or dairy) or intolerances (e.g. lactose)? YES/NO

*If ‘YES’, what are they?*

1. Do you use any of the following:
2. Dietary supplements, e.g. fish oils, evening primrose oil, vitamins or YES/NO minerals (such as iron or calcium);
3. Probiotics, e.g. Actimel, Yakult, Activia yoghurts or capsules; YES/NO
4. Cholesterol-lowering products, e.g. Flora Pro-Activ or Benecol? YES/NO

*If ‘YES’ to any, please give details*

*If ‘YES’ are you willing to stop using these prior to and during the study?* YES/NO

1. Are you vegetarian or vegan? YES/NO

*If ‘YES’, please specify*

1. Are you following or planning to start a restricted diet, e.g. to lose weight? YES/NO

*If ‘YES’, would you be willing to postpone this until after your final study visit?* YES/NO

1. Do you drink alcohol? YES/NO

*If ‘YES’, approximately how many units do you drink per week? \_\_\_\_\_\_\_\_\_\_Units*

*One unit of alcohol is half a pint of beer/lager, a single pub measure of spirits e.g. gin/vodka, or a small glass of wine (125 ml).*

1. Do you exercise more than three times a week, including walking? YES/NO

*If ‘YES’, please specify the type of exercise, frequency and intensity*

1. Do you smoke? YES/NO

*If ‘YES’, please give details: - Type (e.g. cigarettes, pipe, E-cigarettes)*

* *Frequency (e.g. daily, social occasions only)*

*If ‘NO’, did you used to smoke?* YES/NO

*Please tells us when you stopped:*

1. Do you have any holidays/trips planned within the next X months? YES/NO

*If ‘YES’, please give details (e.g. dates and duration):*

**This is the end of the questionnaire - thank you for your time.**

The information you have provided will remain confidential at all times.

Appendix: Compulsory questions for any study using DXA *(REMOVE if not required)*

*Please note that any study using DXA must have prior NHS permission*

1. Do you have any bone related conditions (e.g. osteoporosis) YES/NO
2. Have you ever had any bone fractures or bone related surgeries? YES/NO

*If ‘YES’, please give details:*

1. Do you have any radio-opaque implants such as an artificial joint or pacemaker? YES/NO
2. Have you recently had an X-ray examination or DXA scan? YES/NO

*If ‘YES’, please give details:*