Female Health Questionnaire 2019

Today's Date: 5th July 2021

DETAILS

Your name: Zoe Attkins Age: 3 Date of Birth: 01/06/2018

Email: sienna@androck.com.au

Address: 18 Yule Rd Town: Merewether Postcode: 2291

Phone (H): Mobile:0421551408

Emergency Contact: Sienna Attkins Relationship: Mother

Phone (H): Mobile: 0421551408

How did you hear about this Practice?

☐ Clinic Website ☐ Referral of Doctor ☐ Referral from friend/family member

☐ Social Media ☐ Specialist ☒ Other: OT – Stepping Stones

WHAT ARE YOUR TOP 3 CONCERNS?

1. Nutrition – Zoe has been diagnosed with a genetic condition where they can lend to obesity and the problems associated. I need help to quantify meals so I can make sure she not overeating.
2. Brain Function & Mood– Zoe is delayed developmentally due to the above-mentioned diagnosis I want to make sure we are doing everything we can to make sure she can function healthily as a toddler and navigate the tough moods and frustrations she can get because of this.
3. Food behaviour – Zoe tends to get upset and then request food. Obviously, I don't always let her have some if she does this (especially if she has just eaten) and this can result in big frustrations and meltdowns. Some of her doctors said she might not be feeling "full" due to her condition. Not sure if you can help with this?

HEALTH GOALS

What do you hope to achieve in your visit with me? To support Zoe with her condition and be healthy

When was the last time you felt well? N/A

Did something trigger your change in health? N/A

What makes you feel better? N/A

What makes you feel worse? N/A

How does your condition affect you? Zoe has been diagnosed with Bardet Biedl Syndrome. This can affect her kidney, vision, cause obesity & developmental delays. She currently has a large middle and is over the 99th percentile for weight for age and is developmentally delayed globally (sees speech, physio & OT). She has had high cholesterol on one of her last bloods, and then high lipids at other times. She has had pelvic ultrasounds and has renal cysts and impression of nephrocalenosis. She also sees an ophthalmologist and has an astigmatism and wears glasses (ha-ha we do not wear them all that much yet, but we are trying)

What do you think is happening and why? N/A

What do you think needs to happen for you to get better? This condition is incurable but I hope we can slow or at least lessen some of symptoms for her so she can only be impacted mildly by the disease by living a largely healthy life.

MEDICATIONS & SUPPLEMENTS

Current medications (include prescription and over the counter)

Medication	Dosage	Start Date	Reason for use
NIL			

Nutritional Supplements (Vitamins/ Minerals/ Herbs, etc.)

Name and Brand	Dosage	Start Date	Reason for use
NIL			

How many times have you taken antibiotics?

	Less than 5	More than 5	Reason for use
Infancy/Childhood	☒	☐	Has had a couple of chest infections
Teen	☐	☐	
Adulthood	☐	☐	

LIFESTYLE

Sleep

How many hours of sleep do you get each night on average? 13

Do you have problems falling asleep? ☐ Yes

Do you have problems staying asleep? ☐ Yes

Do you feel rested upon waking? ☐ Yes

Do you use sleeping tablets of some kind? ☐ Yes What are they?

Smoking

Do you smoke currently? ☐ Yes ☒ No Packs per day: Number of years smoking:

How long has it been since you stopped smoking:

Alcohol

How many alcoholic beverages do you drink in a week?

☐ 1-3 ☐ 4-6 ☐ 7-10 ☐ >10 ☒ None

Other substances

Are you currently using or have ever used any recreational drugs? ☐ Yes ☒ No

Environmental/ Detoxification History

Do any of these significantly affect you?

☐ Cigarette smoke ☐ Perfume/ colognes ☐ Auto Exhaust fumes ☐ Other:

Have you had significant exposure to any harmful chemicals? ☐ Yes If yes: Chemical name, length of exposure, date?

Stress

Do you feel you have an excessive amount of stress in your life? ☐ Yes ☐ No

Do you feel you can easily handle the stress in your life? ☐ Yes ☐ No

How much stress do each of the following cause on a daily basis?

(*Rate on a scale of 1-10, 10 being the highest)*

Work: Family: Social: Finances:

Heath: Other:

Relationships

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ De facto ☐ Widow/er

With whom do you live? (Include children, parents, relatives, friends, pets, etc): Parents & little brother

Current occupation: Previous occupations:

Do you have a religious or spiritual practice? ☐ Yes ☒ No

If yes, what kind?

FOOD

Nutrition

Do you currently follow any of the following special diets or nutritional programs? (mark all that apply)

☐ Vegetarian ☐ Vegan ☐ Allergy ☐ Elimination ☐ Low Fat ☐ Low carb

☐ High protein ☐ Blood type ☐ Low sodium ☐ No Dairy ☐ No Wheat

☐ Gluten Free ☐ Other:

Do you have any food sensitivities (known ones, or ones you suspect)? Me (her mother) has coeliac disease so we eat largely gluten free, she has been tested for this and has no antibodies but carries the coeliac gene.

Do you have any strong dislikes for certain foods? Green vegetables ha ha

Are there any foods you crave or binge? Yoghurts in a squeeze pouch

Does skipping a meal greatly affect you? ☐ Yes

How many meals do you eat out per week? ☒ 0-1 ☐ 1-3 ☐ 3-5 ☐ >5 meals per week

Daily diet sample

Please note what you eat in a typical day:

Breakfast: Toast with peanut butter, Yoghurt pouch (usually coconut or lactose free) & Fruit (Blueberries or a banana)

Morning snack: Sultanas

Lunch: Rice cake & nut butter, Zucchini slice

Afternoon Snack: Popcorn, fruit puree pouch

Dinner: Spag bol is fav – added veg to bulk and gf pasta

Drinks: Water

Other: I will offer some fruit if she's still hungry

How many servings do you eat in a typical week of these foods?

Fruits (not juice) ☐ 1 ☐ 2-4 ☒ >4

Vegetables (not including white potatoes) ☐ 1 ☐ 2-4 ☒ >4

Legumes (beans, peas, etc.) ☒ 1 ☐ 2-4 ☐ >4

Red meat ☒ 1 ☐ 2-4 ☐ >4

Fish ☒ 1 ☐ 2-4 ☐ >4

Dairy/ Or alternatives ☐ 1 ☒ 2-4 ☐ >4

Nuts & Seeds ☐ 1 ☐ 2-4 ☒ >4

Fats & Oils ☐ 1 ☒ 2-4 ☐ >4

Sweets (lollies, cookies, cake, ice cream, etc) ☐ 1 ☐ 2-4 ☐ >4

Fluids

How many of these caffeinated drinks:

Coffee (cups per day) ☐ 1 ☐ 2-4 ☐ >4

Tea (cups per day) ☐ 1 ☐ 2-4 ☐ >4

Caffeinated soft drink – Regular or diet (cans per day) ☐ 1 ☐ 2-4 ☐ >4

Do you have any reactions to caffeine? ☐ Yes Describe the reaction eg feel irritable or wired:

Childhood History

You were born: ☒ Full term ☐ Premature ☐ Don't know

Were there any pregnancy or birth complications? ☒ Yes If yes, explain: Gestastional Diabetes, Emergecy C-Section, Posterior Labour

You were: ☒ Breastfed/ How long? 6 weeks ☒ Bottle-fed/ Type of formula:

☐ Don't know

Age of introduction of: Solid food 6 months Wheat 12 months Dairy 12 months

As a child, were there any foods that were avoided because they gave you symptoms? ☐ Yes

If yes, what foods and what symptoms? (Example: Milk = gas and diarrhea):

Did you eat a lot of sugar or sweet foods as a child? ☐ Yes ☒ No

Obstetric History:

Number of pregnancies: Number of children you have given birth to:

Did you develop any problems in or after pregnancy, for example, toxaemia (high blood pressure), diabetes, post-partum depression, issues with breastfeeding, etc.? ☐ Yes

If yes, please list:

Menstrual History:

Age at first period:

Current length of period (blood flow): Days between periods:

Cramping? ☐ Yes Painful? ☐ Yes

Other premenstrual problems (eg. bloating, breast tenderness, irritably, etc.)? ☐ Yes

If yes, please describe:

Do you have other problems with your periods (heavy, irregular, spotting, skipping, etc.)?

☐ Yes If yes, please describe:

Use of hormonal birth control? ☐ The Pill ☐ Other

How long? Any problems with it? ☐ Yes If yes, explain:

Menopause:

Are you in menopause? ☐ Yes ☐ No Date of last menstrual period:

Do you currently have symptomatic problems with menopause? *(Check all that apply)*

☐ Hot flushes ☐ Mood swings ☐ Concentration/memory problems

☐ Headaches ☐ Joint pain ☐ Vaginal dryness ☐ Weight gain

☐ Decreased libido ☐ Loss of control of urine ☐ Palpitations

Are you on hormone replacement therapy? ☐ Yes

If yes, for how long and for what reason (hot flashes, osteoporosis prevention, etc.)?

Other Gynaecological Symptoms:

☐ Endometriosis ☐ Infertility ☐ Fibrocystic breasts ☐ Vaginal infection

☐ Fibroids ☐ Ovarian cysts ☐ Pelvic inflammatory disease

☐ Reproductive cancer ☐ Sexual transmitted disease (what is it):

Clinic use:

Nails Hair

Tongue Skin

Eyes Palmar