**Appendix 2**

**Health and Lifestyle Questionnaire**

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

How did you hear about the study?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Please circle as appropriate*

**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

g) Any illness that may affect the ability of your blood to clot? YES/NO

h) Renal, gastrointestinal, respiratory, liver disease or 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

**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 YES, would you be happy to miss your next blood donation? YES/NO

1. Do you have any food allergies? YES/NO

If 'YES', please give details

1. Do you use any of the following:
2. Dietary supplements, e.g. fish oils, evening primrose oil, vitamins or minerals (such as iron or calcium). YES/NO
3. Foods fortified with protein e.g. yogurt, protein bars, pasta 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

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 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 (284mL of beer/lager, a single pub measure of spirits (25mL ) 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

**Consent**

**Please initial box**

I consent to the use of my personal information in this Health and Lifestyle questionnaire to be used by the (XXXXXXX name of study) study researchers. I understand that the information will be kept confidential.

**Participant details**

Signature: Date:

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

All information provided will remain confidential at all times.