Participant Screening Questionnaire

Today's Date:

Please supply the following information:

Name: _____

Date of Birth: _____

Age: _____

General Practitioner (if known) _____

*Please indicate the ethnicity that you **primarily** identify with*:

NZ European □ Māori □ Samoan □ Cook Island Māori □ Tongan □ Niuean □ Chinese □ Indian □ Other (e.g. Malaysian, Japanese) □

Please state _____

Contact Details:

Home Address:	Work Address:
Telephone Number Home: Mobile:	Telephone Number Home: Mobile:
Email:	Email:
Which phone number/email would you prefer us to use to contact you?	
Can we leave a message with your partner/flatmates/family/Whanau or leave a message on your answer phone? YES ☐ NO ☐	

If your contact details change, please inform us.

Emergency Contact Details:

In the unlikely event of an emergency, please list the name and contact details of the person you would like us to contact and their relationship to you.

We need to record your height and weight for the start of the study. Please ask the researcher present to make these measurements for you.

Height: _____

Weight: _____

BMI: _____

Past Medical History

Please answer the following questions. If answering YES to any of the following, please give as many details as you can such as when you were diagnosed and if the condition is still ongoing.

HAVE YOU SUFFERED FROM	YES	NO	DETAILS
Heart & Circulation			
Heart attack or Angina			
Rheumatic Fever			
Heart murmurs			
High blood pressure			
Anaemia			
Other problems with your heart and circulation (please specify)			
Lung			
Asthma			
Bronchitis/Emphysema			
Tuberculosis (TB)			
Other lung problems (please specify)			

HAVE YOU SUFFERED FROM	YES	NO	DETAILS
Digestive System			
Stomach/duodenal ulcer			
Irritable Bowel Syndrome complicated by diarrhoea			
Irritable Bowel Syndrome complicated by constipation			
Crohn's Disease			
Coeliac Disease			
Indigestion			
Constipation			
Other digestive problems (please specify)			
Neurological System			
Migraine (Number per year)			
Recurring headaches			
Fits			
Head injury with loss of consciousness			
Epilepsy			
Faints			
Blackouts			
Other neurological problems (please specify)			

HAVE YOU SUFFERED FROM	YES	NO	DETAILS
Kidney/Liver/Serious Infections			
Hepatitis			
Jaundice (at what age?)			
Kidney or gall stones			
Recurrent cystitis			
Other kidney/liver or serious infections (please specify)			
Hormones			
Diabetes			
Thyroid Disorder			
Other hormone problems (please specify)			
Skin			
Psoriasis			
Dermatitis			
Eczema			
Other skin problems (please specify)			
Joint/Muscle/Bone			
Arthritis			
Other (Please specify)			

HAVE YOU SUFFERED FROM	YES	NO	DETAILS
Allergies			
Hayfever			
Other allergies (please specify) Exactly what are you allergic to? What happens to you e.g. rash, swelling, breathing difficulties?			
Psychiatric			
Have you ever suffered or do you suffer with anxiety attacks or depression? If YES, can you provide us with details of: When this happened? Was this caused by a specific event? Your treatment e.g. did you require counselling, psychiatric referral, medication?			
Have you ever suffered or do you suffer with an eating disorder?			
Have you ever received treatment or a psychiatric disorder?			
Hospital Attendance			
Have you ever attended hospital • As inpatient? • As an outpatient?			
Have you ever undergone an operation or any surgical procedure? (Please indicate approximate dates)			

Please list any medications you are taking for your medical conditions. Please state the **dosage** and when you **started** taking this medication.

MEDICATION	Date Started	Dosage

Are you currently taking laxatives. If yes, what/dose/frequency?

_____

_____

Are you currently taking any dietary supplements? This includes products such as Metamucil and Benefibre? If yes, what/dose/frequency?

_____

_____

In the last two week have you consumed Yakult, Acitvate or any other probiotic fermented milk drink? If yes, which brand and approximately how much do you consume/week?

_____

_____

CURRENT HEALTH

Please answer the following questions. If answering YES to any of the following, please give as much detail as possible.

CURRENT HEALTH	YES	NO	DETAILS
Smoking/Alcohol/Recreational Drugs			
Do you smoke? • If YES, how many per day? • If a previous smoker, please state when you gave up • How many did you smoke? • Do you use nicotine replacement therapy?			
Do you drink alcohol? • If YES, on average how many units a week do you drink? (1 unit = ½ pint beer/ ~300ml or 1 glass of wine or 1 measured spirit)			
Do you take recreational drugs e.g. cannabis/ecstacy?			
Immunisations/vaccinations			
• Have you required travel or work related immunisations within the last 3 months? • Are you undergoing a course of vaccinations?			
Tattoos/Piercings			
Do you have tattoos or body piercings?			

Physical Activity

Please indicate how much physical activity you participate in:

LEVEL OF ACTIVITY	Tick one
Sedentary – no exercise	
Mild exercise – i.e. climbing stairs, walk ~15 minutes, golf	
Occasional vigorous exercise – work or recreation, less than 4x/week for 30 minutes	
Regular vigorous exercise –work or recreation 4x/week for at least 30 minutes	

Other Information

Is there any other information, not discussed, that you feel relevant regarding your health?

_____

_____

FEMALE PARTICIPANTS ONLY

Are you post-menopausal? Yes/No

If not, can you please state the date of your last menstrual period? _____

How would you describe your menstrual cycle? Regular/Irregular

On average can you please state the number of days in your cycle? _____

Is it possible that you may be currently or may wish to become pregnant in the next 24 weeks? Yes/No

DECLARATION BY PARTICIPANT:

I (print name) _____ have given true and complete information to the best of my knowledge.

Signature: _____ Date: _____

Researcher: _____ Date: _____