Optimum Nutrition Questionnaire

Symptoms Analysis

For each symptom that you experience often, score 1 point. Many symptoms occur more than once, because they can be the result of many nutrient deficiencies. If you experience any of the symptoms in **bold** type, score 2 points. The maximum score for each nutrient is 10 points. Put your score for each in the nutrient box.

Vitamin A		Vitamin D		Vitamin E	
	Mouth Ulcers		**Arthritis or osteoporosis**		Lack of sex drive
	Poor night vision		Backache		**Exhaustion after light exercise**
	Acne		Tooth decay		**Easy bruising**
	Frequent colds or infection		Hair loss		Slow wound healing
	Dry flaky skin		**Muscle twitching or spasms**		Varicose veins
	Dandruff		**Joint pain or stiffness**		Poor skin elasticity
	Thrush or cystitis		Weak bones		Loss of muscle tone
	Diarrhea		*Your Score*		Infertility
	Your Score				*Your Score*
Vitamin B1		Vitamin B2		Vitamin B3 (Niacin)	
	Tender muscles		**Bloodshot, burning, or gritty eyes**		Lack of energy
	Eye pains		**Sensitivity to bright lights**		Diarrhea
	Irritability		Sore tongue		Insomnia
	Poor concentration		Cataracts		Headaches or migraines
	Prickly legs		Dull or oily hair		Poor memory
	Poor memory		Eczema or dermatitis		Anxiety or tension
	Stomach pains		Split nails		Depression
	Constipation		Cracked lips		Irritability
	Tingling hands		*Your Score*		*Your Score*
	Rapid heartbeat				
	Your Score				

Vitamin B5		Vitamin B6		Folic Acid	
	Muscle tremors, cramps, or spasms		**Infrequent dream recall**		Eczema
	Apathy		**Water retention**		Cracked lips
	Poor concentration		Tingling hands		Prematurely graying hair
	Burning feet or tender heels		Depression or nervousness		Anxiety or tension
	Nausea or vomiting		Irritability		Poor memory
	Lack of energy		Muscle tremors, cramps, or spasms		**Lack of energy**
	Exhaustion after light exercise		**Lack of energy**		Depression
	Anxiety or tension		*Your Score*		Poor appetite
	Teeth grinding				Stomach pains
	Your score				*Your Score*
Vitamin B12		Biotin		Vitamin C	
	Poor hair condition		**Dermatitis or dry skin**		**Frequent colds**
	Eczema or dermatitis		**Poor hair condition**		Lack of energy
	Mouth over sensitive to heat or cold		**Prematurely graying hair**		**Frequent infections**
	Irritability		**Tender or sore muscles**		Bleeding or tender gums
	Anxiety or tension		**Poor appetite or nausea**		Easy bruising
	Lack of energy		*Your Score*		Nosebleeds
	Constipation				Slow wound healing
	Tender or sore muscles				Red pimples on skin
	Pale skin				Acne
	Your score				*Your Score*
Calcium		Iron		Magnesium	
	Muscle cramps, tremors, or spasms		**Pale skin**		Muscle cramps, tremors, or spasms
	Insomnia or nervousness		**Sore tongue**		Muscle weakness
	Joint pain or arthritis		**Fatigue or listlessness**		**Insomnia, nervousness, or**

					hyperactivity
	Tooth decay		**Loss of appetite or nausea**		High blood pressure
	High blood pressure		**Heavy periods or blood clots**		Irregular or rapid heartbeat
	Your Score		*Your Score*		Constipation
					Fits or convulsions
					Breast tenderness or water retention
					Depression or confusion
					Your Score
Manganese		Chromium		Zinc	
	Muscle twitches		**Excessive or cold sweats**		**Decline in sense of taste or smell**
	Childhood "growing pains"		**Dizziness or irritability after 6 hrs. without food**		**White marks on more than two fingernails**
	Dizziness or poor sense of balance		**Need for frequent meals**		**Frequent infections**
	Fits or convulsions		**Cold hands**		**Stretch marks**
	Sore knees		**Need for excessive sleep or drowsiness during the day**		**Acne or greasy skin**
	Your Score		*Your score*		*Your Score*
Selenium		Omega 6 / Omega 3			
	Family history of cancer		**Dry skin or eczema**		Poor memory or learning difficulties
	Signs of premature aging		Dry hair or dandruff		High blood pressure or high blood lipids
	Cataracts		Inflammatory conditions such as arthritis		*Your Score*
	High blood pressure		Excessive thirst or sweating		
	Your Score		PMS or breast pain		
			Water retention		
			Frequent infections		

Lifestyle Analysis

The following checks allow you to adjust your nutrient needs according to aspects of your health and lifestyle. Again, answer the questions as best you can and work out your score. In most checks, the maximum score is 10, scoring 1 point for each yes answer unless otherwise specified. If you score 5 or more in any category, you will need to add the points shown in the chart at the end of this questionnaire to your individual nutrient scores. The easiest way to do this is to circles all the numbers in the corresponding columns in the chart at the end of this questionnaire. For example, if you score more than 5 on the energy check, you would circle all the numbers in the energy column in the chart at the end of this questionnaire. Some checks are either yes or no. If you answer yes, circle the numbers in the relevant columns in the chart at the end of this questionnaire.

Energy Check

_____ Do you need more than eight hours' sleep at night?
_____ Are you rarely wide awake and raring to go within 20 minute of rising?
_____ Do you need something to get you going in the morning like a cup of tea, coffee, ' or cigarette?
_____ Do you have tea, coffee, or sugar-containing foods or drinks, or smoke cigarettes at regular intervals during the day?
_____ Do you often feel drowsy or sleepy during the day or after meals?
_____ Do you get dizzy or irritable if you have not eaten for six hours?
_____ Do you avoid exercise because you do not have the energy?
_____ Do you sweat a lot during the night or day or get excessively thirsty?
_____ Do you sometimes lose concentration or does your mind go blank?
_____ Is your energy less now than it used to be?
_____ *YOUR SCORE*

Stress Check

_____ Do you feel guilty when relaxing?
_____ Do you have a persistent need for recognition or achievement?
_____ Are you unclear about your goals in life?
_____ Are you especially competitive?
_____ Do you work harder than most people?
_____ Do you easily get angry?
_____ Do you often do tow or three tasks simultaneously?
_____ Do you get impatient if people or things hold you up?
_____ Do you have difficulty getting to sleep, sleep restlessly, or wake up with your mind racing?
_____ *YOUR SCORE*

Exercise Check

_____ Do you take exercise that noticeably raises your heartbeat for at least twenty minutes more than three times a week?
_____ Does your job involve lots of walking, lifting, or any other vigorous activity?
_____ Do you regularly play a sport (football, squash, and so on)?
_____ Do you have any physically tiring hobbies (gardening, carpentry, and so forth)?
_____ Are you in serious training for an athletic event?
_____ Do you consider yourself fit?
_____ *YOUR SCORE*

Immune Check

_____ Do you get more than three colds a year?
_____ Do you find it hard to shake an infection (cold or otherwise)?
_____ Are you prone to thrush or cystitis?
_____ Do you generally take antibiotics twice or more each year?
_____ Have you had major personal loss in the past year?
_____ Is there any history of cancer in your family?
_____ Have you ever had any growths or lumps removed or biopsied?
_____ Do you have an inflammatory disease such as eczema, asthma, or arthritis?
_____ Do you suffer from hay fever?
_____ Do you suffer from allergy problems?
_____*YOUR SCORE*

Pollution Check

_____ Do you live in a city or by a busy road?
_____ Do you spend more than two hours a week in heavy traffic?
_____ Do you exercise (do your job, cycle, play sports) by a busy road?
_____ Do you smoke more than five cigarettes a day?
_____ Do you live or work in a smoky atmosphere?
_____ Do you buy foods exposed to exhaust fumes from busy roads?
_____ Do you generally eat non-organic produce?
_____ Do you drink more than one unit of alcohol a day (one glass of wine, one pint or 600 ml of beer, or two shots)?
_____ Do you spend a considerable amount of time in front of a TV or computer screen?
_____ Do you usually drink unfiltered tap water?
_____ *YOUR SCORE*

Cardiovascular Check

_____ Is your blood pressure above 140/90?
_____ Is your pulse rate after fifteen minutes rest above 75?
_____ Are you more than 14 pounds above your ideal weight?
_____ Do you smoke more than five cigarettes a day?
_____ Do you do less than two your of vigorous exercise (one hour if you're over 50) a week?
_____ Do you eat more than one tablespoon of sugar each day?
_____ Do you eat meat more than five times a week?
_____ Do you usually add salt to your food?
_____ Do you have more than two alcoholic drinks (or units of alcohol) a day?
_____ Is there a history of hear disease or diabetes in your family?
_____ *YOUR SCORE*

Female Health Check

Are you pregnant or trying to get pregnant? *Yes / No*
Are you breast feeding? *Yes / No*
Do you regularly suffer from premenstrual syndrome? *Yes / No*
Do you have menopausal symptoms or are you post menopausal? *Yes / No*

Age Check

Are you under 14? *Yes / No*
Are you 14 to 15? *Yes / No*
Are you over 50? *Yes / No*

From *The New Optimum Nutrition Bible* by Patrick Holford p. 393 - 399