

THE MATOL DIET



DIETER HEALTH PROFILE

A Matol Diet consultation involves a health profile whose purpose is not to establish a medical diagnosis, but rather to determine a dieter's health status in order to guide their weight loss plan. A dieter may be advised to consult a physician based on their health profile.

GENERAL INFORMATION

Date: _____

Last Name: _____ First Name: _____

Address: _____

City: _____ State/Province: _____

Zip/Postal Code: _____ Tel: (Daytime) _____ (Evening) _____

Cell Number: _____ E-Mail: _____

Gender: F M Date of Birth: _____ Age: _____ Profession: _____

What time do you usually go to sleep? _____ What time do you usually wake up? _____

On a scale of 1-10, indicate what level of importance you give to the Matol Diet treatment (10 being the most important): _____

MARITAL STATUS

What is your marital status? _____

Do you have children? Yes No Number of children _____ Ages: _____

Are you pregnant? Yes No N/A Are you breast-feeding? Yes No N/A

MEDICAL INFORMATION

Diabetes:

Do you have diabetes? Yes No

If yes, are you under the care of a physician? Yes No

If yes, which type? Type I Type II Insulin or pills required

Is your blood sugar level monitored? Yes No

Is yes, by whom? Myself Physician Other: specify _____

Are you taking any medication? Yes No

If yes, please list: _____

Are you hypoglycemic? Yes No Are you hyperglycemic? Yes No Do not know

Cardiovascular Disease:

Have you ever had a cardiovascular disease or episode? Yes No

If yes, please specify _____ How long ago? _____

If yes, are you under the care of a physician? Yes No

If yes, are you taking any medication? Yes No

If yes, please list: _____

Do you suffer from hypertension (high blood pressure)? Yes No

If yes, do you have your blood pressure monitored? Yes No

If yes, are you under the care of a physician? Yes No

If yes, are you taking any medication? Yes No

If yes, please list: _____

Kidney Function:

Have you been diagnosed with kidney dysfunction? Yes No

If yes, are you under the care of a physician? Yes No

If yes, are you taking any medication? Yes No

If yes, please list: _____

Liver Function:

Do you have liver problems? Yes No

If yes, please specify _____

If yes, are you under the care of a physician? Yes No

If yes, are you taking any medication? Yes No

If yes, please list: _____

Digestive Function:

Do you suffer from: Irritable colon Colitis Diarrhea
Diverticulitis Crohn's disease Constipation

If yes, are you under the care of a physician? Yes No

If yes, are you taking any medication? Yes No

If yes, please list: _____

Stomach Function:

Do you suffer from: Acid reflux Gastric ulcer Heartburn

If yes, are you under the care of a physician? Yes No

If yes, are taking any medication? Yes No

If yes, please list: _____

GYN/OBS: N/A

Please indicate the approximate date of your next menstrual cycle: _____

Check off any of these conditions that are applicable to you:

Menopause Mammography Hysterectomy
Amenorrhea (absence of menstruation) Uterine fibroma Cancer (uterus, breast)

Menstrual cycle: Irregular Heavy Painful

If so, are you under the care of a physician? Yes No

If yes, are you taking any medication? Yes No

If yes, please list: _____

Thyroid Function:

Do you have an overactive thyroid Yes No Do you have an underactive thyroid? Yes No

If yes, are you under the care of a physician? Yes No

If yes, are you taking any medication? Yes No

If yes, please list: _____

Cancer:

Do you have cancer? Yes No

If yes, specify the type and for how long: _____

Are you in remission? Yes No

If yes, please specify the type and for how long: _____

If yes, are you under the care of a physician? Yes No

Are you taking any medication? Yes No

If yes, please list: _____

Emotional Evaluation:

Check off any of these conditions that are currently or were previously applicable to you:

Migraines Panic attacks Spasmophilia

Depression Bulimia Anorexia

If so, are you under the care of a physician? Yes No

If yes, are you taking any medication? Yes No

If yes, please list: _____

Allergies:

Do you have food allergies? Yes No

If yes, please list: _____

Do you have any other health problems? Yes No

If yes, please specify: _____

If yes, are you under the care of a physician? Yes No

If yes, are you taking any medication? Yes No

If yes, please list: _____

Are you taking other medication? Yes No

Drug Name:	Since:	Reason:
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____

Eating Habits:

Breakfast:

Do you have breakfast every morning? Yes Sometimes Never

Example 1: _____

Example 2: _____

Do you have a snack before lunch? Yes Sometimes Never

Example 1: _____

Example 2: _____

Lunch

Do you have lunch every day? Yes Sometimes Never

Example 1: _____

Example 2: _____

Do you have a snack before dinner? Yes Sometimes Never

Example 1: _____

Example 2: _____

Dinner

Do you have dinner every day? Yes Sometimes Never

Example 1: _____

Example 2: _____

Evening

Do you snack after dinner? Yes Sometimes Never

Example 1: _____

Example 2: _____

Do you snack at night? Yes Sometimes Never

Example 1: _____

Example 2: _____

Other:

Do you prefer: Sweet foods Salty foods Fatty foods

How many glasses of water do you drink daily? _____ glasses.

How many cups of coffee or tea do you drink daily? _____ cups.

Do you drink alcohol? No Sometimes Weekends Regularly

Do you smoke? Yes No

Are you a vegetarian? Yes No

Have you been on a diet before? Yes No

If yes, please specify: _____
_____ Diet ended: _____

You acknowledge that the daily intake of all four Matol nutritional supplements is mandatory during the length of the Matol Diet to fulfil you with all the necessary nutrients. If you stop taking the nutritional supplements, as directed, at any time during the Matol Diet, you may experience undesirable side effects.

_____ (Dieter's initials)

Signature of dieter

Date

The signatory dieter hereby recognizes the veracity of the information provided herein and that they have made an informed decision to go on the Matol Diet.