WOMEN'S HEALTH HISTORY FORM

All of your information will remain confidential.

PERSONAL INFORMATION

Name:

Email:

How often do you check e-mail:

Home Phone:

Work Phone:

Mobile Phone:

Age: Height: Birthdate:

Place of Birth:

Current Weight: Weight 6 months ago: Weight 1 year ago:

Would you like your weight to be different?: yes no If yes, what?

SOCIAL INFORMATION

Relationship Status:

Where do you currently live?:

Children:

Pets:

Occupation:

Hours of work per week:

HEALTH INFORMATION

Please list your main health concerns

Other concerns and/or goals?:

At what point in your life did you feel best? :

Any serious illnesses/hospitalizations/injuries?:

How is/was the health of your mother?:

How is/was the health of your father?:

What is your ancestry?:

What blood type are you?:

How is your sleep?:

How many hours?:

Do you wake up at night?

Why?

Any pain, stiffness or swelling?:

Constipation/Diarrhea/Gas?:

Allergies or sensitivities? Please explain:

Are your periods regular?

How many days is your flow? How Frequent?

Painful or symptomatic? Please explain:

Reached or approaching menopause? Please explain:

Birth Control History

Do you experience yeast infections or urinary tract infections? Please explain:

MEDICAL INFORMATION

Do you take any supplements or medications? Please list:

Any healers, helpers or therapies with which you are involved? Please list:

What role do sports and exercise play in your life?:

FOOD INFORMATION

What foods did you eat often as a child?
Breakfast:

Lunch:

Dinner:

Snacks:

Liquids:

Will family and/or friends be supportive of your desire to make food and/or lifestyle changes?:

Do you cook?:

What percentage of your food is home-cooked?:

Where do you get the rest from?:

Do you crave sugar, coffee, cigarettes, or have any major addictions?:

The most important thing I should do to improve my health is:

What is your food like these days?
Breakfast:

Lunch:

Dinner:

Snacks:

Liquids:

Additional Comments

Anything else you would like to share?: