

Women's Health History

(Confidential)

Please write or print clearly

Today's Date: _____

First Name: _____ Last Name: _____

Address: _____

Email Address: _____ How often do you check email? _____

Cell #: _____ Work #: _____ Home #: _____

Preferred form of contact: Email Text Cell Work Home

Age: _____ Height: _____ Weight: _____

Weight 6 months ago: _____ Weight a year ago: _____ Ideal Weight _____

Relationship Status: _____ Living in a: House Apt/Condo/Multi-Family

Children: _____ Pets: _____

Occupation: _____ Hours worked per week: _____

Will family/friends be supportive of your food/lifestyle changes? Yes No Maybe

Date of Birth: _____ Place of Birth: _____

What is your ancestry? _____ Blood Type: _____

How was the health of your father? _____

How was the health of your mother? _____

Please list your main health concerns: _____

Any serious illnesses/hospitalizations/injuries? (please list in detail with dates – use separate sheet if necessary) _____

What role does sports/exercise play in your life? _____

Do you sleep well? Yes No Sometimes How many hours?

Do you wake up at night? Yes No Sometimes Why?

Describe any pain, stiffness, swelling: _____

Describe any Constipation/Diarrhea/Gas: _____

What medical/healers/therapy providers do you work with? _____

List all medications or supplements: _____

Known allergies or sensitivities: _____

Do you crave sugar, coffee, cigarettes, or have any addictions? (describe) _____

What foods did you eat most often as a child?

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Liquids: _____

What foods do you eat most often now?

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Liquids: _____

What percentage of your food is home cooked? _____ Do you cook? _____

Where does the rest of your food come from? _____

The most important thing I should change about my diet to improve my health is: _____

My primary health/fitness/nutritional goals are: _____

My primary concerns about reaching those goals are: _____

At what point in your life did you feel at your best/healthiest? _____

Is there anything else you'd like to share? _____

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WOMEN ONLY

Are you Premenopausal Yes No

Are you Menopausal Yes No

Are you Postmenopausal Yes No Age at completing menopause _____

If you are still having periods:

Are your periods regular? Yes No

How frequent? _____ How many days is your flow? _____

Are your periods painful or symptomatic? Please explain _____

How many pregnancies have you had? _____

Number of live births _____

Number of miscarriages _____

Do you now, or have you ever, taken birth control? Yes No

If Yes please explain: _____

Do you experience yeast infections or urinary tract infections? Yes No

If Yes please explain: _____
