

**Women’s Confidential Health History**

Please write or print clearly

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| Name:  |   |

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| Address: |   |

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| Email address: |   | How often do you check email? |   |

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| Telephone – Work: |   | Home: |   | Cell: |   |

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| Age: |  | Height: |   | Date of Birth: |   | Place of Birth: |   |

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| Current weight: |   | Weight six months ago: |   | One year ago: |   |

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| Would you like your weight to be different? |   | If so, what? |   |

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| Relationship status: |   |

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| Children: |   | Pets: |   |

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| Occupation: |   | Hours of work per week: |  |

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| Please list your main health concerns: |   |
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| Other concerns and/or goals? |   |
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| At what point in your life did you feel best? |   |

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| Any serious illnesses/hospitalizations/injuries? |  |
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| How is the health of your mother? |   |

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| How is the health of your father? |   |

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| What is your ancestry? |   | What blood type are you? |   |

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| Do you sleep well? |   | How many hours? |   | Do you wake up at night? |   |

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| Why? |   |

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| Any pain, stiffness or swelling? |   |

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| Are your periods regular? |  | How many days is your flow? |  | How frequent? |  |

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| Painful or symptomatic? Please explain: |  |

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| Reached or approaching menopause? Please explain: |  |

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| Birth control history: |   |

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

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| Do you have any digestive issues? Do you experience pain/gas/bloating/heartburn after eating? Constipation/Diarrhea/Gas? Please explain: |   |

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| Allergies or sensitivities? Please explain: |   |

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| Any other medical conditions now or historically? Please list:  |  |

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| Do you take any supplements or medications? Please list: |   |
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| Any healers, helpers or therapies with which you are involved? Please list: |   |
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| What role does sports and exercise play in your life? |   |
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| **What foods did you eat often as a child?**  |

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| Breakfast |  | Lunch |  | Dinner |  | Snacks |  | Liquids |
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| What’s your food like these days?  |

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| Breakfast |  | Lunch |  | Dinner |  | Snacks |  | Liquids |
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| Will family and/or friends be supportive of your desire to make food and/or lifestyle changes? |   |

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

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| Where do you get the rest from? |   |

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| Do you crave sugar, coffee, cigarettes, or have any major addictions? |  |
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| The most important thing I should change about my diet to improve my health is: |  |
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| Anything else you want to share? |
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