**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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