**Women’s Confidential Health History**

Please write or print clearly

|  |  |
| --- | --- |
| Name:  |   |

|  |  |
| --- | --- |
| Address: |   |

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

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

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

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

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

|  |  |
| --- | --- |
| Relationship status: |   |

|  |  |  |  |
| --- | --- | --- | --- |
| Children: |   | Pets: |   |

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

|  |  |
| --- | --- |
| 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 the health of your mother? |   |

|  |  |
| --- | --- |
| How is the health of your father? |   |

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

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

|  |  |
| --- | --- |
| Why? |   |

|  |  |
| --- | --- |
| Any pain, stiffness or swelling? |   |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 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: |   |
|  |

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

|  |  |
| --- | --- |
| Allergies or sensitivities? Please explain: |   |

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

|  |  |
| --- | --- |
| Do you take any supplements or medications? Please list: |   |
|  |

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

|  |  |
| --- | --- |
| What role does sports and exercise play in your life? |   |
|   |

|  |
| --- |
| **What foods did you eat often as a child?**  |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Breakfast |  | Lunch |  | Dinner |  | Snacks |  | Liquids |
|  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |

|  |
| --- |
| What’s your food like these days?  |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Breakfast |  | Lunch |  | Dinner |  | Snacks |  | Liquids |
|  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |

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

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

|  |  |
| --- | --- |
| Where do you get the rest from? |   |

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

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

|  |  |
| --- | --- |
| Anything else you want to share? |  |
|   |
|  |