Women's Health History Form

Personal Information		
First & Last Na	nme:	
• Date of Birth: _		
Contact Inform	nation:	
• Emergency Co	ntact:	
Occupation:		_
Marital Status:		_

Lifestyle and Habits

Dietary Patterns:

- Describe your typical daily meals and snacks:
- Do you follow any specific diet (e.g., vegetarian, keto)?
- How often do you consume processed foods or sugary beverages?

Physical Activity:

- What forms of exercise do you engage in, and how frequently?
- Do you have any physical limitations?

Sleep	Patterns:
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- Average hours of sleep per night:
- Do you experience sleep disturbances?

Stress and Mental Health:

- On a scale of 1-10, rate your current stress level: _____
- Do you have coping mechanisms for stress? If so, what are they?

Substance Use:

- Do you smoke or use tobacco products?
- Is alcohol consumption part of your routine? If so, how often?
- Do you use recreational drugs?

Medical History

Pregnancy and Childbirth:

- Number of pregnancies: _______
- Number of births: _____
- Any complications during pregnancy or delivery?
- Have you experienced childbirth-related traumas? If comfortable, please elaborate:

Medical Conditions:

•	List any chronic illnesses or co	onditions:
•	Are you currently on any med	lications or supplements?
Family •	y Medical History: Any hereditary conditions in y	our family (e.g., diabetes, heart disease)?
	organal Incights	
Pe	ersonal Insights	
Astrol	logical Information:	
•	Birth Date ar	nd Time:

Cultural and Spiritual Beliefs:

• Do you adhere to specific cultural or spiritual practices that influence your health decisions?

Health Goals and Concerns:

• What are your primary health goals?

Birthplace: _______

