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Please fill out as much of this form as you would like to. We will complete your health herstory when we see you for your appointment. Thank you in advance.

Name \_\_\_\_\_  
Last First Middle

First name you prefer to use \_\_\_\_\_ Date of birth \_\_\_\_\_

Address \_\_\_\_\_  
Street City State Zip

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Alternate Phone \_\_\_\_\_ E-mail \_\_\_\_\_

Would you like to be added to our e-mail list to receive periodic updates on classes, groups, events and new program offerings at WomanSafeHealth? (please circle): Yes / No

Emergency Contact Person \_\_\_\_\_ Relationship \_\_\_\_\_ Phone # \_\_\_\_\_

Insurance Policy Holder Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Please bring insurance information with you.

Name of person who referred you to WomanSafeHealth \_\_\_\_\_

Your occupation \_\_\_\_\_

Reason for your visit today \_\_\_\_\_

### Health Herstory

Last medical visit and with whom \_\_\_\_\_

Primary health care provider \_\_\_\_\_ Address \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_ (Info needed to send records)

Other health care providers \_\_\_\_\_

Last pap test results and date \_\_\_\_\_

Last cholesterol results and date \_\_\_\_\_

Last mammogram results and date \_\_\_\_\_

Do you do Self Breast Exam? \_\_\_\_\_

[www.womansafehealth.com](http://www.womansafehealth.com)

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Current medications and dosages \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Current herbs/supplements/homeopathic medications \_\_\_\_\_

\_\_\_\_\_

Allergies and reactions \_\_\_\_\_

Please list any major illnesses you have had and dates:

\_\_\_\_\_

\_\_\_\_\_

Please list any surgeries or hospitalizations you have had and dates:

\_\_\_\_\_

\_\_\_\_\_

### **Gynecological Herstory**

First day of Last Menstrual Period, if applicable \_\_\_\_\_ Regular, every \_\_\_\_\_ days; or Irregular \_\_\_\_\_

How old were you when your periods first started \_\_\_\_\_ Length of flow \_\_\_\_\_

Recent changes in your period/ Any problems \_\_\_\_\_

### **Obstetrical Herstory**

Any herstory of infertility? \_\_\_\_\_

Total number of pregnancies \_\_\_\_\_ Number of biological, adopted, foster or step-children \_\_\_\_\_

Number of months or years you have breastfed a baby \_\_\_\_\_

### **Family Herstory**

Please indicate if anyone in your immediate family has had any of the following and who it was (brother, sister, mother, father, maternal or paternal grandmother or grandfather):

Alcoholism/ Addiction

Breast/ Ovarian/ Endometrial Cancer

Colon/ Prostate Cancer

Depression/ Bipolar Disorder

Diabetes

Heart disease/ Heart attack

High blood pressure

High cholesterol

Osteoporosis

Stroke/ Clots in legs or arms (DVT)

Thyroid Disease