The Woman Kind Practice CLIENT MEDICAL HISTORY

This questionnaire has been designed to provide valuable information to assist us in determining how we can help you. Please bring the completed form to your appointment.

Client Name:..... M/F
Address:……. ……. D.O.B.: Age:
……..
……... Height: Weight:
Tel. No. Day: email:
Eve:
G.P. Name, Address & Tel No: ……
……...

Occupation:
Status: Married / Divorced / Single / Separated / Widowed / Other
No. & Age of Children / Dependants;
Are you pregnant? If so, how many months? Date of your last period?
Are you on HRT? The Pill? Do you have a coil fitted?
Do you smoke? If so, how many a day?
How often do you exercise? - Occasionally / Regularly / Never. What type?

What are your hobbies and interests?

Details of prescribed medication and self medication / Vits & Mins inc. Homeopathic. What is it for?

Do you suffer from any of the following? Tick if they apply.
Heart problems? Diabetes? Cancer? Thyroid? Aids? TB?
Pacemaker? Epilepsy? Osteoporosis Varicose veins?
Allergies? Dyslexia ?

Pain – Where?

How many cups of tea a day do you drink? Milk Sugar, If so how much?
How many cups of coffee a day do you drink? Milk Sugar, If so, how much?
How much plain water do you drink a day? Do you drink alcohol?
How many units a week?
What fruit juices or squashes do you drink? How much salt do you use?

Describe a typical days diet including snacks

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