General Information

Name____

Gender____________________

What do you prefer to be called?_________________________________

Street Address____

City_________________________ State__________ Zip___________

Phone Number____

Email____

Preferred Contact Mode (please check one) Phone_____ Email_____

Birth Date____________________ SSN__________________________

Primary Physician____

Primary Physician Contact Info____________________________________

Emergency Contact____

Medical History

Allergies____

____

Current Medications and Supplements_______________________________

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Family Medical History (if known) __________________________________

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Past Surgeries (and year)____

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Current Medical Status (Diabetes, Hypothyroid, RA, Cancer, Asthma, etc….)

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Current or Recurring Pain (location and quality of pain-dull, achy, stabbing…)

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Menses History: (if applicable)

Age at First Menses____________ Length of Cycle__________________

Days of Flow ____________ Clots/Color of Clots_______________

Heavy or Light Flow (during beginning and end)_______________________

____

Color of Blood (Bright or dark red, purple, brownish, pinkish-during which part of flow)____

PMS Symptoms (before or during)_________________________________

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Cramps/Pain (before or during cycle)_______________________________

Signature ___________________________________ Date ____________

Printed Name ____