Seasons of Life Women's Health *Brigitte Rhody- Garrison, CNM*

Please complete these forms and bring along to your first appointment.

NAME: **DATE of BIRTH:** **AGE:**

ADDRESS: **BEST PHONE:**

E MAIL: **PHARMACY:**

MARITAL STATUS: MUTUALLY MONOGAMOUS? EMPLOYER:

DRUG OR ENVIROMENTAL ALLERGIES:

CURRENT MEDICATIONS and SUPPLEMENTS (attach list if need more space):

CURRENT HEALTH CONCERNS OR PROBLEMS: (list/ explain)

LAST PAP: EVER HAVE ABNORMAL PAP? LAST LAB DRAW/ TESTS:

FAMILY HISTORY- any diseases or relevant problems within family?

LIFESTYLE and NUTRITION:
DESCRIBE YOUR EATING HABITS:

UNITS CAFFFEINE USE DAILY/ WEEKLY:
UNITS ALCOHOL USE DAILY/ WEEKLY:
TOBACCO USE? STREET DRUGS?
HEIGHT: WEIGHT: ISSUES WITH WEIGHT/ DIET?

EXERCISE/ FREQUENCY:
DO YOU ENJOY EXERCISE?

ENERGY LEVEL:

OB /GYN HISTORY: How many times have you been pregnant?
List all children, name and date of birth along with any other pregnancy outcomes.

LAST MENSTRUAL PERIOD: **PROBLEMS WITH PERIOD:**

CURRENTLY SEXUALLY ACTIVE?

BIRTH CONTROL METHOD: **HAPPY WITH THAT METHOD?**
FEELINGS AND ATTITUDES ABOUT SEX, SEXUALITY OR INTERCOURSE:

SURGICAL HISTORY: please list date and type of any surgeries in your past

ANY OTHER INFORMATION THAT WOULD BE HELPFUL FOR US TO KNOW? (Feel free to use other side of this sheet if need more space.)