



Center for Integrative Medicine & Wellness
Personal Health Inventory

Name: _____ Today's Date _____
Date of Birth: _____

Primary Care Physician _____ Phone _____
Specialty Physician _____ Phone _____
Specialty Physician _____ Phone _____

Current Concerns (Please rank by priority)	Onset	Frequency	Severity
Example: Stress	June 1998	4 times/wk	mild/mo/severe
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____
5. _____	_____	_____	_____

What are your goals for this visit?

Medical History

Personal History

- Anemia
- Cancer
- Diabetes
- Digestive
- Eating Disorder
- Heart Disease
- Hepatitis
- Hypertension
- Lung Disease
- Mitral Valve Prolapse
- Seizures
- Thyroid Disease
- Other _____
- _____

Family History

Surgical History

Date _____
Date _____
Date _____
Date _____

Medication:

	Medication Name	Reason for Use	Dosage/Date Started
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____

Dietary Supplements, Vitamins and Minerals:

	<u>Brand/Manufacturer</u>	<u>Reason</u>	<u>Date Started</u>	<u>Dosage Per Day</u>
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____
5.	_____	_____	_____	_____
6.	_____	_____	_____	_____
7.	_____	_____	_____	_____
8.	_____	_____	_____	_____
9.	_____	_____	_____	_____
10.	_____	_____	_____	_____