

MEDICAL HEALTH INVENTORY -- **CONFIDENTIAL**

Name: _____

Date: _____

Date of last physical exam: _____ Findings: _____

Any pertinent medical history: _____

Any significant medical problems in family? _____

Are you currently under medical treatment? Yes No If "Yes," Please detail: _____

MEDICATIONS: Have you ever taken the following medications on a regular basis? _____

Aspirin or Pain Reliever Sleeping Pill Antidepressant Lithium
 Pain Relieving Drug Tranquilizer Blood Pressure Medication Anti-anxiety

If currently taking medication, please list below, including all herbal remedies and any dietary supplements:

Medication / Supplement	Dose (how much / how often?)	How Taken? (pills, liquid, etc.)	Comments
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please inform me if / when current medications / dosages are changed, discontinued, or added. Thank you.

Current Symptoms:

Are you experiencing any of the following? Please indicate which ones:

Weakness Lack of Interest Palpitations Anxiety Feelings of Guilt
 Depression Fearfulness Anger Family Problems Sleep disturbance
 Feelings of Inferiority Crying Easily Seeing Things Hearing Voices Indecisiveness
 Paranoia Poor Attention Span Irritability Low Self-esteem Inability to Relax
 Agitation Personality Changes Nightmares Socially Withdrawn Tiring Easily
 Dry Mouth Physical Complaints Numbness Short tempered Racing Heart
 Inability to have fun Suicidal Feelings Panic Attacks Constant Worry Appetite disturbance
 Low Energy Generalized anxiety Weight loss Weight gain Suspiciousness
 Phobias Avoiding people Excessive worrying Tension Numbness Elated/Euphoric Mood
 Lack of libido Feelings of Hopelessness Shaky Hands/tremulousness Obsession/Compulsion

Other: _____

Health Problems:

Have you ever had any of the following health problems?

Tension Headache Heart Attack/Heart Disorder Epilepsy Migraine Headache
 Lung /Respiratory Disorder Cancer TMJ Disorder Liver Disease or Hepatitis
 Insomnia Chronic Back Pain Kidney Disorder/Stones Asthma
 Chest Pain / Angina Urinary / Bladder Disorder Allergies Abdominal Pain
 Skin Disorder/Eczema/Hives Peptic Ulcer Pelvic or Genital Pain High Blood Pressure
 Colitis IBS Arthritis Low Blood Pressure
 Diabetes Bone Fracture Hypoglycemia Concussion
 Post Polio Pre-Menstrual Syndrome/Cramps Deafness Thyroid Disorder
 Prostate or Vaginal Disorder Tinnitus Sexually Transmitted Disease

OTHER ILLNESSES: What other serious illnesses have you had? _____

Conditions: Have you frequently experienced any of the following symptoms?

Cold Hands or Feet Excessive Sweating Colds or Flu Swollen Ankles or Feet
 Difficulty Sleeping Sore Throat Stiff, Aching Joints Overeating or Binge Eating
 Dizziness Neck or Shoulder Tension Diarrhea Grinding Your Teeth
 Job Dissatisfaction Constipation Ringing in Ears Sex Life Not Satisfying
 Nausea, Vomiting Rapid Heartbeat Lack of Fun or Affection Hyperventilation
 Short-term Memory Loss Long-term Memory Loss Blurred Vision Under eating or Poor Appetite

Accidents: Have you ever been injured in an accident? If yes, note when and please detail: _____

Items: Do you have any of the following more than twice a day?

Ice Cream Glass of Beer or Wine Can of Soda Pop Cigarette
 Cup of Coffee Liquor or Cocktail Recreational Drug Chocolate