TRIVITA CLINIC
of INTEGRATIVE MEDICINE

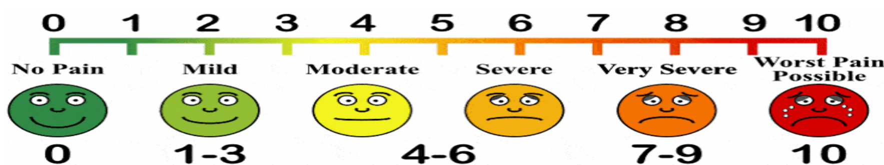
Patient Name: ____ Date: _______________

1. What is the main purpose of your visit today? ___________________________________
   ____
2. Are there any other medical concerns you would like addressed today? Please keep in mind, if you have multiple conditions we may need to schedule subsequent visits so your health concerns can receive the time and attention they deserve.
   I. ____
   II. ____
3. Please list any medications you need refilled

Medication Name	Pharmacy Name/Cross Streets

4. Approximately when was your last annual physical exam? ________________________
5. Circle symptoms that you have experienced within the past 2 weeks or reoccurring
   A. Respiratory issues: If yes explain____
   B. Gastrointestinal issues: If yes explain_____________________________________
   C. Urinary or genital issues: If yes explain_____________________________________
   D. Toenail or fingernail fungus? If yes explain__________________________________
   E. Re-occurring or slow healing wounds: If yes explain___________________________
   F. Trouble falling or staying asleep
   G. Feelings of sadness / anxiety / memory loss
   H. Seasonal allergies / do you have allergies
   I. Numbness or tingling in arms or legs / difficulty concentrating / headaches / falls
   J. Vision changes / ear pain / nasal congestion / sinus pain / sore throat / fever / fatigue / weight loss / unintentional weight gain
   K. Painful urination / blood in urine / discharge / pelvic pain / irregular periods / excessive thirst / frequent urination / swollen lymph nodes
   L. Cough / shortness of breath / wheezing / chest pain
   M. Swelling / irregular heart beat
   N. Black stool / blood in stool / changes in bowel function
   O. Eczema / changes in moles / rash
   P. Arm or leg pain / back pain / neck pain / joint pain / other pain

Indicate pain level today



PLEASE NOTE: Our Medical Providers are here to address your health concerns however some concerns may require a separate visit.