Yu Wang M.D. Family Medicine

Name_____

In order to better assess your health condition, please provide the following information.

YES	NO	**PAST MEDICAL HISTORY**	**RESPIRATORY SYSTEM**	YES	NO
		1.Allergies	42.Chronic/Recurrent/Cough/Cold		
		2.Medications	43.Asthma/Wheezing		
		3.Major illnesses or injuries	44.Emphysema or chronic bronchitis		
		4.Hospitalizations or surgeries	45.Pneumonia		
		5.Motor vehicle accidents	46.Tuberculosis		
		6.Blood transfusions	47. Coughing of Blood		
		7.Worked in a hazardous environment	**GASTROINTESTINAL TRACT**	YES	NO
		8.Worked-related injuries/illnesses	48.Frequent Indigestion or reflux		
		9.Permanent disabilities	49.Nausea or vomiting		
YES	NO	**FAMILY HISTORY**	50.Vomiting of Blood		
		10.Blood diseases in relatives	51.Abdominal pain		
		11.Cancer or leukemia in relatives	52. Liver disease		
		12.Diabetes in relatives	53.Change in Bowel Habits		
		13.Heart Disease in relatives	54.Frequent Constipation/Diarrhea		
		14.High Blood Pressure in relatives	55.Blood in stools/Black stools		
		15.Strokes in relatives in relatives	56.Hemorrhoids/Rectal Disease		
		16.Mental illnesses in relatives	**GENITOURINARY TRACT**	YES	NO
		SOCIAL HISTORY	57. Painful or difficult urination		
		17.Tobacco use. How much? week	58. Blood in urine		
		18.Alcohol use. How much? week	59.Kidney infection/stones		
YES	NO	**REVIEW OF SYSTEMS**	60.Venereal Disease		
		Have you had or do you commonly have?	**MUSCULOSKELETAL**	YES	NO
YES	NO	**CONSTITUTIONAL**	61.Joint pain or disease		
		19.Recent gain or loss of weight	62. Neck or back injury		
		20.Weakness, fatigue, or appetite loss	63. Foot problems		
		21.Fever	**NEUROLOGICAL**	YES	NO
YES	NO	**SKIN**	64. Epilepsy		
		22.Skin diseases or problems	65. Dizziness		
		23.Discoloration,pigmentation changes	66. Muscle weakness		
		24.Cancer/Tumors or cysts	67. Tingling or numbness in arms or legs		
YES	NO	**HEAD**	**PSYCHIATRIC PROBLEMS**	YES	NO
		25.Frequent or severe headaches	68. Depression		
YES	NO	**EYES/VISION**	69. Nervousness		
		26.Eye injury, infection or pain	70. Mood swings		
		27. Blurred, double or decreased vision	71. Sleep disturbances		
		28. Eye itching, burning or tearing	72. Alcoholism		
		29.Light sensitivity	73. Drug abuse		
YES	NO	**EARS,NOSE,THROAT,MOUTH**	**ENDOCRINE SYSTEM**	YES	NO
		30. Loss or decreased hearing	74. Increased appetitie		
		31. Ear pain, infection, discharge	75. Increased thirst		
		32. Nose/ Sinus Problems	76. Increased urination		
		33.Dental/ Gum Disease	77. Diabetes/ High blood sugar		
		34. Recurrent throat problems	78. Hair loss		
		35. Voice change/ hoarseness	79. Thyroid disorder		
YES	NO	**CARDIOVASCULAR SYSTEM**	**BLOOD DISORDERS**	YES	NO
		36. Shortness of breath	80. Bleeding gums		
		37. Chest pain or pressure	81. Easy bruising/ bleeding		
		38. Palpitation/ Pounding heart	82. Spontaneous nose bleeding		
		39. High blood pressure	**FOR WOMEN ONLY**	YES	NO
		40. Swelling feet/ ankle	83. Pregnant		
		41. Varicose veins	84. Date of last menstrual period___		
			85. Irregular menstruation		
			86. Painful menstruation		

Please write the number of any YES answers and explain each one of them in the space below.

I certify that the information above is correct.

Patient signiture:_____ Date:_____