Yu Wang M.D. Family Medicine

Name _____

In order to better assess your health condition, please provide the following information.
为了更好的评价您的健康情况，请您提供以下信息

YES	NO	PAST MEDICAL HISTORY (既往史）是否曾有过?	RESPIRATORY SYSTEM（呼吸系统）	YES	NO
		1.Allergies/ 过敏	42.Chronic/Recurrent/Cough/Cold/慢性咳嗽		
		2.Medications/现用药	43.Asthma/Wheezing/哮喘		
		3.Major illnesses or injuries/ 主要疾病或创伤	44.Emphysema or chronic bronchitis/肺气肿，慢支		
		4.Hospitalizations or surgeries/ 住院或手术史	45.Pneumonia/肺炎		
		5.Motor vehicle accidents/ 交通事故	46.Tuberculosis/肺结核		
		6.Blood transfusions/ 输血史	47. Coughing of Blood/咳血		
		7.Worked in a hazardous environment/ 曾在危险环境下工作	**GASTROINTESTINAL TRACT（消化系统）**	YES	NO
		8.Worked-related injuries/illnesses/ 工伤	48.Frequent Indigestion or reflux/消化不良，反酸		
		9.Permanent disabilities/ 残疾	49.Nausea or vomiting/恶心，呕吐		
YES	NO	**FAMILY HISTORY （家族史）家族中是否有?**	50.Vomiting of Blood/呕血		
		10.Blood diseases in relatives/ 家族血液系统疾病	51.Abdominal pain/腹痛		
		11.Cancer or leukemia in relatives/家族癌症	52. Liver disease/肝脏疾病		
		12.Diabetes in relatives/ 家族糖尿病	53.Change in Bowel Habits/大便习惯改变		
		13.Heart Disease in relatives/ 家族心脏病	54.Frequent Constipation/Diarrhea频繁便秘或腹泻		
		14.High Blood Pressure in relatives/ 家族高血压	55.Blood in stools/Black stools/便血，黑便		
		15.Strokes in relatives in relatives/ 家族中风史	56.Hemorrhoids/Rectal Disease/痔疮，直肠疾病		
		16.Mental illnesses in relatives/ 家族精神病史	**GENITOURINARY TRACT（泌尿系统）**	YES	NO
		SOCIAL HISTORY （社会史）	57. Painful or difficult urination/排尿疼痛或困难		
		17.Tobacco use. How much? Week/ 吸烟？/每周	58. Blood in urine/血尿		
		18.Alcohol use. How much? Week/ 喝酒？/每周	59.Kidney infection/stones肾脏感染，结石		
YES	NO	**REVIEW OF SYSTEMS （系统回顾）**	60.Venereal Disease/性病		
		Have you had or do you commonly have?	**MUSCULOSKELETAL（骨骼肌肉系统）**	YES	NO
		是否曾经或现在有以下情况？	61.Joint pain or disease/关节痛或疾病		
YES	NO	**CONSTITUTIONAL （身体总体状况）**	62. Neck or back injury/颈部或背部损伤		
		19.Recent gain or loss of weight/ 近期体重变化	63. Foot problems/足病		
		20.Weakness, fatigue, or appetite loss/ 虚弱，乏力，厌食	**NEUROLOGICAL（神经系统）**	YES	NO
		21.Fever/ 发烧	64. Epilepsy/癫痫		
YES	NO	**SKIN （皮肤）**	65. Dizziness/头晕		
		22.Skin diseases or problems/ 皮肤疾病	66. Muscle weakness/肌无力		
		23.Discoloration,pigmentation changes/ 色素改变	67. Tingling or numbness in arms or legs		
		24.Cancer/Tumors or cysts/ 皮肤癌或囊肿	67. 肢体针刺感或麻木		
YES	NO	**HEAD （头部）**	**PSYCHIATRIC PROBLEMS（精神疾病）**	YES	NO
		25.Frequent or severe headaches/ 频繁或严重的头痛	68. Depression/抑郁		
YES	NO	**EYES/VISION （眼睛/视力）**	69. Nervousness/精神紧张		
		26.Eye injury, infection or pain/ 眼睛损伤，感染或疼痛	70. Mood swings情绪不稳		
		27. Blurred, double or decreased vision	71. Sleep disturbances/睡眠不好		
		27. 视力模糊，双影或视力减退	72. Alcoholism/酗酒		
		28. Eye itching, burning or tearing/ 眼睛痒，烧灼感或流泪	73. Drug abuse/吸毒		
		29.Light sensitivity/ 光敏感	**ENDOCRINE SYSTEM（内分泌系统）**	YES	NO
YES	NO	**EARS,NOSE,THROAT,MOUTH（耳，鼻，喉）**	74. Increased appetitie/食欲增加		
		30. Loss or decreased hearing/视力减低	75. Increased thirst/易渴		
		31. Ear pain, infection, discharge/耳痛，感染，分泌液	76. Increased urination/多尿		
		32. Nose/ Sinus Problems/鼻及鼻窦疾病	77. Diabetes/ High blood sugar/糖尿闭		
		33.Dental/ Gum Disease/牙齿及牙龈疾病	78. Hair loss/脱发		
		34. Recurrent throat problems/喉咙疾病	79. Thyroid disorder/甲状腺疾病		
		35. Voice change/ hoarseness/声音改变，沙哑	**BLOOD DISORDERS（血液系统）**	YES	NO
YES	NO	**CARDIOVASCULAR SYSTEM（心血管系统）**	80. Bleeding gums/牙龈出血		
		36. Shortness of breath/气短	81. Easy bruising/ bleeding/易青紫，出血		
		37. Chest pain or pressure/胸痛	82. Spontaneous nose bleeding/自发流鼻血		
		38. Palpitation/ Pounding heart/心悸	**FOR WOMEN ONLY（妇科）**	YES	NO
		39. High blood pressure/高血压	83. Pregnant/怀孕		
		40. Swelling feet/ ankle/脚踝肿	84. Date of last menstrual period /末次月经日期		
		41. Varicose veins/静脉曲张	85. Irregular menstruation/月经不规则		
			86. Painful menstruation/痛经		

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. Date:_____
Patient signiture:_____