PATIENT QUESTIONNAIRE / Dr. Yee Clinic

INSTRUCTIONS: For Follow-up visit check either "No Change" or "New info and correct/add information.

PATIENT NAME: _____

ALLERGIES:
❑ No Change ❑ New Info
❑ None List: _____

FAMILY HISTORY:
❑ No Change ❑ New Info
(Circle those that are positive) **None** Heart Disease Lung Disease Kidney Disease Rheumatoid Arthritis Cancer Other _____

MEDICAL HISTORY:
❑ No Change ❑ New Info

❑ **None**
HEENT ❑ Blindness ❑ Deafness ❑ Vertigo
NECK: ❑ Disc Bulge Cervical Spine ❑ Thyroid Disease
LUNGS: ❑ Asthma ❑ COPD - Emphysema
HEART: ❑ Heart Attack ❑ Arrhythmia and/or Pacemaker ❑ Congestive Heart Failure ❑ Hypertension ❑ Congenital Condition ❑ Stents or Bypass ❑ Blood Vessel Disease ❑ Other _____
ABDOMEN: ❑ Ulcer (Healed? Yes / No) ❑ Hiatal Hernia / Reflux ❑ Liver Disease / Hepatitis ❑ Kidney Disease ❑ Irritable Bowel Disease ❑ Crohn's Disease ❑ Diverticulitis ❑ Other _____
NEUROLOGICAL: ❑ Stroke ❑ Parkinson's disease ❑ Paralysis
BLOOD: ❑ Anemia ❑ Clotting Problems ❑ Coumadin / Blood Thinner
MUSCULOSKELETAL: ❑ Neck Pain ❑ Back Pain ❑ Osteoarthritis ❑ Rheumatoid Arthritis ❑ Lupus
NERVOUS DISORDER: ❑ Depression ❑ Anxiety ❑ Other _____
ENDOCRINE: ❑ Diabetes
OTHER CONDITIONS: _____

MEDICATION:
❑ No Change ❑ New Info
(by other physicians) List: _____

SURGERY HISTORY:
❑ No Change ❑ New Info
List: _____

SOCIAL HISTORY:
❑ No Change ❑ New Info
Do you smoke? Yes No **Do you drink alcohol?** Yes No

REVIEW OF SYSTEMS: ❑ No New Problem(s) ❑ Yes - New Complaint(s)

(Repeat Visit - Mark only the NEW symptoms that you have experienced since your last visit)

GENERAL	❑ Fever	❑ Weight Loss	❑ Weight Gain
EYES	❑ *Blurring*	❑ *Loss of Vision*	
EARS/NOSE/THROAT	❑ Ringing in the Ears	❑ Decreased Hearing	
CARDIOVASCULAR	❑ *Difficulty Breathing While Lying Down*	❑ *New Chest Pain or Discomfort*	❑ *Palpitations* ❑ *New Leg Swelling*
RESPIRATORY	❑ Coughing Up Blood	❑ New Shortness of Breath	
GASTROINTESTINAL	❑ *Vomiting Blood*	❑ *Bloody Stools*	❑ *New Abdominal Pain*
URINARY	❑ Blood in Urine	❑ New Inability to Control Bladder	
MUSCULOSKELETAL	❑ *Gout*		
SKIN	❑ Rash	❑ New Open Wound	
NEUROLOGICAL	❑ *Brief Paralysis*	❑ *New Numbness*	❑ *New Tingling*
ENDOCRINE	❑ Excessive Thirst	❑ Excessive Hunger	
HEME/LYMPHATIC	❑ *Abnormal Bruising*		
ALLERGIC/IMMUNOLOGIC	❑ Hives	❑ HIV Exposure	

I HAVE REVIEWED AND CORRECTED THE ABOVE INFORMATION

Patient or Representative Signature _____ Date _____ Physician _____