

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

☐ New Open Wound

SKIN

☐ Rash

☐ New Numbness

☐ New Tingling

NEUROLOGICAL

☐ Brief Paralysis

☐ Excessive Hunger

ENDOCRINE

☐ Excessive Thirst

HEME/LYMPHATIC

☐ Abnormal Bruising

ALLERGIC/IMMUNOLOGIC

☐ Hives

☐ HIV Exposure

I HAVE REVIEWED AND CORRECTED THE ABOVE INFORMATION

Patient or Representative Signature

Date

Physician

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