Medical Question

Name _____ Date of Birth ____/____/____ Age _____

Address _____ Phone Number _____ □ Male □ Female

If we cannot contact you,who should we contact?

Name _____ Phone Number _____

1. What kind of symptoms do you have?

□ sore throat □ coughing □ sputum □ sneezing and running nose □ nausea

□ vomiting □ diarrhea □lack of appetite □ feverish □ chill □ general fatigue

What kind of pain?

□ stomach pain □ lower abdominal pain (□ sharp □ dull □ stinging □ intermittent)

2. Since when have you ever been having the symptom(s)?

□ since _____ □ for the past _____ days / weeks / month

3. How are the symptom(s)?

□ continuing □ getting worse □ occasionally □ gradually getting better

【Please circle YES or NO and provide additional details where requested.】

4. Have you ever had any similar symptoms before?

NO YES When? _____

5. Did you consult a doctor then?

NO YES What treatment? _____

6. Are you allergic to any medication (aspirin, penicillin, sulfa, etc.) or any food?

NO YES list _____

Please turn over.

7. Do you have any blood relatives who have the same allergy?

NO YES list _____

8. Do you take any prescribed medication on a permanent or semi-permanent basis?
(steroids, anti-inflammatories, antibiotics, insulin, etc.)

NO YES list _____

9. Do you have, or have you ever had the following diseases?

Heart disease NO YES give name and date _____
Glaucoma (high intraocular pressure) NO YES give date _____
Enlarged prostate (men only) NO YES give date _____

10. Do you have, or have you ever had any diseases other than the above?

NO YES give name and date _____

11. Are you presently receiving any treatment for the disease(s)?

NO YES Where? _____

12. Do you smoke? NO YES

13. Do you drink alcohol? NO YES

(Question for women)
14. Are you pregnant? NO YES

15. Are you breastfeeding? NO YES

16. How did you get information about this clinic?

_____

If you have the list of the medicine you are being prescribed, please hand it to a nurse.
Thank you.