NAME

WHAT IS YOUR CURRENT AGE?

WHY ARE YOU SEEING DR. YONG?

WHICH OF THE FOLLOWING SYMPTOMS DO YOU HAVE? ❑ abdominal pain ❑ nausea ❑ vomiting ❑ difficulty swallowing ❑ heartburn ❑ blood in stool ❑ diarrhea ❑ constipation ❑ difficulty sleeping ❑ decrease in energy ❑ decrease in appetite ❑ unexplained weight loss ❑ unexplained fevers ❑ chest pain ❑ shortness of breath

PLEASE LIST ALL PREVIOUS MEDICAL CONDITIONS.

PLEASE LIST ALL PREVIOUS SURGERIES.

PLEASE LIST ALL CURRENT MEDICATIONS.

Name	Dose	Frequency

PLEASE LIST ALL DRUG ALLERGIES.

HOW MUCH ALCOHOL DO YOU CONSUME PER WEEK?

HOW MANY CIGARETTES DO YOU SMOKE PER DAY?

DO YOU USE ANY ILLICIT DRUGS?

WHAT IS YOUR MARITAL STATUS?

HOW MANY CHILDREN DO YOU HAVE?

WHAT IS YOUR EMPLOYMENT STATUS?

WHERE WERE YOU BORN?

WHERE HAVE YOU TRAVELLED IN THE PAST YEAR?

DO YOU HAVE ANY DIETARY RESTRICTIONS?

NAME

CURRENT ADDRESS

DAYTIME TELEPHONE NUMBER

CAN WE LEAVE PERSONAL MESSAGES? ❑ yes ❑ no

EVENING TELEPHONE NUMBER

CAN WE LEAVE PERSONAL MESSAGES? ❑ yes ❑ no

NAME OF EMERGENCY CONTACT

TELEPHONE NUMBER

WOULD YOU LIKE ALL COMMUNICATIONS TO BE WITH YOUR EMERGENCY CONTACT? ❑ yes ❑ no

NAME OF REFERRING DOCTOR

NAME OF FAMILY DOCTOR

ADDRESS

TELEPHONE NUMBER

FAX NUMBER

PHARMACY NAME

PHARMACY LOCATION

PHARMACY PHONE NUMBER

PHARMACY FAX NUMBER