

Please print all four pages, fill out, and mail to:

Dr. Yang's Family Care
10201 Mission Gorge Road, Suite A
Santee, CA 92071

Name _____ Date _____

Address _____

City _____ State _____ Zip _____

General Questions

Do you remember having been bitten by a tick? YES NO When? _____

Have ticks been found on your pets? YES NO When? _____

Frequent outdoor activities:

Hiking _____ Fishing _____ Camping _____ Gardening _____ Hunting _____

Where? _____

Do you remember having a "bull's eye" rash? YES NO When? _____

Where on your body? _____

Have you had any other rashes? YES NO When? _____

Where on your body? _____

Did any other members of your family become ill about the same time as you? YES NO

Do any other members of your family have symptoms similar to yours? YES NO

Heavy Metals/Mercury

Have you had any dental procedures done recently? YES NO

Any fillings replaced recently? YES NO Type? _____

Did you begin to exhibit symptoms after dental work? YES NO When? _____

Any exposure to a broken thermometer? YES NO When? _____

Have you made any home improvements recently? YES NO

List:

Exposure to heavy metals, weed killers, chemicals? YES NO

List:

Other Exposures

Have you been exposed to cats? YES NO When? _____

Were you involved in the Gulf War? YES NO When? _____

Did one or more family members become ill after eating? YES NO When?

Symptoms Checklist

Name _____ Date _____

**OFFICE
USE
ONLY**

Do You Have Or Have You Had Any Of The Following

If you experience a listed problem, please insert a number 1-5 in the box corresponding to the frequency of your symptoms: 1 being minimal and 5 severe.	Y E S	N O	C O N S T A N T	D A I L Y	W E E K L Y	M O N T H L Y	R A R E L Y	Comments	Tyne	Babesia or WAI	Ehrlichia	Bartonella	Mercury/Heavy M
General Well Being													
1. Unexplained weight loss or gain (circle), amount # _____													
2. Extreme Fatigue													
3. Swollen Glands: List areas _____ _____													
4. Continual infections (sinus, kidney, eye, etc.)													
5. Experienced a flu like illness, after which you have not felt well since													
6. Symptoms seem to change, come and go													
7. Pain migrates (moves) to different parts of the body													
8. Exaggerated symptoms or worse hangover from alcohol													
9. Chronic pain: list areas _____ _____													
10. Tooth pain													
11. Nose Bleeds													
12. Allergies													
Head – Face - Neck													
13. Unexplained hair loss													
14. Headaches													
15. Twitching of facial or neck muscles													
16. Facial paralysis (Bell's Palsy)													
17. Tingling of nose, cheek, or face													
18. Stiff or painful neck													
19. Jaw pain or stiffness													
20. Sore throat													
Eyes/Vision													
21. Double or blurry vision													
22. Increased floating spots													
23. Pain in eyes													
24. Swelling around eyes													
25. Oversensitive to light													
26. Sensitivity to flashing lights													
27. Blind spots													
28. Nightblindness													
Page 1 Subtotal													

Name _____

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Ears / Hearing													
29. Decreased hearing in one or both ears													
30. Buzzing or ringing in ears													
31. Pain in ears													
32. Dizziness													
33. Motion sickness													
Digestive and Excretory													
34. Diarrhea													
35. Constipation													
36. Irritable bladder (trouble starting or stopping)													
37. Upset stomach, nausea or vomiting													
Musculoskeletal System													
38. Joint pain or swelling; list joints _____													
39. Stiffness of joints, back, neck													
40. Muscle pain or cramps													
41. Muscle tightness													
42. Feeling like your bones hurt													
43. Have you been diagnosed as having arthritis?													
Respiratory and Circulatory Systems													
44. Shortness of breath													
45. Chest pain or rib soreness													
46. Heart seems to have extra beats or racing pulse													
47. Any history of heart problems													
48. Loss of sex drive													
49. Unexplained menstrual pain													
50. Unexplained breast pain													
51. Unexplained milk production													
52. Testicular or pelvic pain													
Temperature Control													
53. Body temperature fluctuations													
54. Flushing													
55. Intolerance to heat or cold													
56. Decreased body temperature (below 98 ⁰)													
57. Low grade fevers													
58. Night sweats													
59. Chills													
Page 2 Subtotal													

Name _____

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Neurologic System													
60. Headaches / migraine													
61. Pressure in head													
62. Numbness anywhere													
63. Tingling or pinprick sensations													
64. Burning sensations													
65. Crawling sensations under the skin													
66. Stabbing sensations													
67. Tremors													
68. Twitching													
69. Fainting													
70. Spastic movements													
71. Do you drop objects often?													
72. Are you accident prone?													
Psychological													
73. Sudden, abrupt mood swings													
74. Unusual depression													
75. Disorientation (getting or feeling lost)													
76. Feeling as if you are losing your mind													
77. Explosive anger													
78. Decreased frustration tolerance													
79. Paranoia													
80. Overemotional reactions / crying easily													
81. Sleeping too much													
82. Difficulty falling or staying asleep													
83. Do you think about suicide?													
84. Do you have homicidal thoughts?													
85. Do you have generalized anxiety?													
86. Have you decreased social functioning?													
87. Has your job/school performance decreased?													
88. Are you obsessive/compulsive?													
Page 3 Subtotal													
Page 2 Subtotal													
Page 1 Subtotal													
Multiply by			5	4	3	2	1						
TOTAL													

Name _____