

CCACU Pan Asian Volunteer Health Clinic

Patient's Demographics and Authorization

Date: _____ (mm/dd/yy)

Patient Demographics 病患个人信息

Family Name 姓: _____ Middle Initial _____ Name in Chinese Character _____

First Name 名: _____ 中文姓名: _____ Sex(性別): M _____ F _____

Date of Birth 出生月/日/年: _____ SSN #: _____

Marital Status 婚姻狀況: () Single () Married () Widowed () Other _____

Address 地址: _____

City 城市: _____ State 州: _____ Zip 邮编: _____

電話 Home Phone: () _____ Can we leave message 留言? () Yes () No

Work/ Mobile: () _____ Can we leave message 留言? () Yes () No

Email: _____ Can we send you information on PAVHC 留言? () Yes () No

Pharmacy(藥房名): _____

Pharmacy Address(藥房地址): _____

Pharmacy Tel.(藥房電話): _____ Pharmacy Fax(藥房傳真): _____

The Authorize PAVHC to share health information to your reprehensive person? 授權給代表人分享
医疗信息 () Yes () No

If yes, name of individual _____; Relationship with patient _____

Email: _____ Tel: _____

Emergency contact name & phone number, different from home 非同住之緊急聯絡人

Name 姓名 _____ Phone 電話 _____ Relationship 關係 _____

Signature of Patient /Authorized Representative

Print Name

MEDICAL HISTORY

病歷

病人姓名：

DOB：_____

Past Medical History and Review of Systems

Please circle the problems you had before or have now:

請圈選曾患過或現有之症狀

- | | | |
|----------------------------|----------------------------------|----------------------------|
| 1. High blood pressure 高血壓 | 17. Hay fever 枯草熱 | 33. Irradiation 放射治療 |
| 2. Diabetes 糖尿病 | 18. Abdominal pain 腹痛 | 34. Headache 頭痛 |
| 3. Cancer 癌症 | 19. Indigestion 消化不良 | 35. Kidney disease 腎臟病 |
| 4. Heart disease 心臟病 | 20. Nausea 噁心 | 36. Kidney stone 腎結石 |
| 5. Chest discomfort 胸部不適 | 21. Vomiting 嘔吐 | 37. Urinating problem 泌尿問題 |
| 6. Shortness of breath 氣喘 | 22. Constipation 便秘 | 38. Arthritis 關節炎 |
| 7. Swollen ankles 腳腫 | 23. Diarrhea 腹瀉 | 39. Low back pain 腰背痛 |
| 8. Dizziness 頭暈 | 24. Blood in stool 便血 | 40. Skin disease 皮膚病 |
| 9. Palpitation 心悸 | 25. Peptic ulcer 消化性潰瘍 | 41. Blood disorder 血液病 |
| 10. Frequent urination 頻尿 | 26. Weight loss 體重減輕 | 42. Venereal disease 性病 |
| 11. Rheumatic fever 風濕熱 | 27. Hemorrhoids 痔瘡 | 43. Anxiety 焦慮症 |
| 12. Asthma 哮喘 | 28. Gall bladder disease 膽囊病 | 44. Depression 憂鬱病 |
| 13. Bronchitis 支氣管炎 | 29. Colitis 大腸炎 | 45. Anemia 貧血 |
| 14. Pneumonia 肺炎 | 30. Hepatic disease 肝病 | 46. Gout 痛風 |
| 15. Persistent cough 久咳 | 31. Change in bowel habit 大便習慣改變 | |
| 16. T.B. 結核病 | 32. Thyroid disease 甲狀腺疾病 | |

Others 其他：_____

Allergies to Medications, X-Ray dyes, or Other Substances ?

對藥物、X光顯影劑或其他醫藥物有無過敏？ Yes 是 No 無

Name of medicine Type of reaction

藥物名稱 反應狀況

Regular medication (name and dosage) 日常服用之藥名及劑量：

Operations 曾作過之手術：

(next page please) 請接下頁

Do you smoke 您抽煙嗎? No 不

Yes 有 , packs/day 每天包數 _____

Do you drink 您喝酒嗎? No 不

Yes 有 , how much/often 數量/次數 _____

Immunization history and preventive medicine 疫苗接種及預防醫學記錄:

Pneumovax 肺炎疫苗 No 無 Yes 有 , When 何時? _____

Flu shot 流行性感胃 No 無 Yes 有 , When 何時? _____

Hepatitis B: B 型肝炎 No 無 Yes 有 , When 何時? _____

Tetanus 破傷風 No 無 Yes 有 , When 何時? _____

The most recent date of the following exams 曾於何時作過下列檢查?

Pap smear 子宮頸抹片 _____

Breast exam 乳房檢查 _____

Mammogram 乳房攝影 _____

Stool for blood 大便潛血 _____

Prostate exam 攝護腺 _____

Cholesterol check 膽固醇 _____

Family History 家族史:

Has any member of your family (parents, grandparents, siblings) ever had the followings ?

您的祖父母, 父母, 兄弟姐妹曾患有下列疾病嗎?

Illness 病名	Family member 家屬關係	Age of onset 發病年齡
Cancer (type) 癌症 (種類) _____	_____	_____
High blood pressure 高血壓	_____	_____
Heart disease 心臟病	_____	_____
Diabetes 糖尿病	_____	_____
Stroke 中風	_____	_____
Mental disease 精神疾病	_____	_____
Bleeding disease 出血疾病	_____	_____
Others 其他: _____	_____	_____

Signature 簽名: _____

Date 日期: _____