PATIENT INFORMATION SHEET

Referred by_____ Date:_____/_____/_____

Name:_____**Date of Birth**____/____/_____
名字 Last 姓 Middle First 名 生日 月 日 年

Home Address: _____
現在住址 CITY 城市 ZIP 邮编

Cell / Business Phone :_____Home Phone: _____
手機/工作電話 家庭電話

Email Address:_____WeChat:_____

Employer:_____Occupation:_____

Business Address:_____Social Security No. _____

HUSBAND OR RESPONSIBLE PARTY Marriage Status: Single___Married___Divorced___Widowed___
配偶信息
名字 Last 姓 Middle First 名 生日 月 日 年

Name:_____Date of Birth____/____/_____

Relationship:_____Social Security No. _____

Cell / Business Phone:_____Home Phone: _____
手機/工作電話 家庭電話

Employer:_____Occupation:_____

Business Address: _____

NOTIFY IN EMERGENCY 緊急聯絡人

Name:_____Relationship: _____
名字 與你的關係

Phone:_____Address: _____
電話 地址

- Insurance Company_____Effective Date____/____/_____
- Address _____
- Policy No._____Group No. _____

Please indicate blew which phone and address you would like to be contacted regarding the treatment or test results.

Home___ Work___ Cell ___ NO, DO NOT contact me.__

I certify upon my honor, that I answer the preceding questions truthfully and accurately to my best knowledge and ability.

► **Signature:**_____**Date**____/____/_____
簽名 日期 月 日 年

Miracle Orchids Medical Center
新病人問卷 New Patient Questionnaire

姓名 Name:_____ 生日 Date of Birth:_____ 日期 Date:_____

懷孕紀錄 Pregnancy History

懷孕次數 Number of pregnancies_____ 足月產次數 Full-term delivery_____ 早產次數 Preterm delivery (<37 周)_____
墮胎次數 Abortion_____ 流產次數 Miscarriage_____ 宮外孕次數 Ectopic pregnancy_____
多胞胎次數 Multiple Birth_____ 現有孩子數 Living _____

生產日期 Date	生產時週數 Baby Weeks	寶寶出生體重 Baby Weight	性別 Sex	生產方式 Type Delivery	出生地點 Place of Delivery	併發症 Complication
				順/剖 Vaginal/C-section		
				順/剖 Vaginal/C-section		
				順/剖 Vaginal/C-section		
				順/剖 Vaginal/C-section		
				順/剖 Vaginal/C-section		

月經紀錄 Menstrual History

末次月經第一天 First Day of the Last Period _____每個月都來月經 Monthly(Y/N)_是 / 否_月經週期頻率 Frequency_____
月經持續天數 Last for How Many Days_____ 幾歲來第一次月經 When do you have your 1st period _____yrs old

婦科紀錄 Gynecologic History

上次宮頸抹片(宮頸刮片或塗片)日期 Last PAP Smear	/ /
曾有不正常宮頸抹片紀錄? Abnormal PAP history	是/否 Y/N _____年 yr
上次做乳房攝影(鉬靶) Last Mammogram	/ /
避孕方式 Method of Contraception	
停經時間 When Did You Go Through Menopause	/ /
上次骨質密度測試? Last Bone Scan(DEXA), If any	
上次大腸鏡測試? Last Colonoscopy? If any	

手術紀錄 Surgical History

手術日期 Date	手術項目 Type	手術醫院 Where

藥物紀錄 Current Medication

現在有服用任何藥物嗎? 請列出藥名 Are you currently taking any medication? Please list:

_____

_____

是否有藥物過敏的紀錄? 是 /否 Do you have drug allergies? Y/N

請列出藥名和反應 Please list medication and reaction

_____

社交史 Social History

是否抽菸 Do you smoke?_Y/N___數量和菸齡 Amount and years_____上次使用時間 Last time you smoke_____

是否喝酒 Do you drink?_Y/N____數量和種類 Amount and type_____上次使用時間 Last time you drank_____

是否嗑藥 Do you use recreation drug?_Y/N___類型和藥齡 Type and years_____上次使用時間 Last use_____

個人疾病史 Medical History

- ☐ 心臟疾病 Heart Disease
- ☐ 高血壓 Hypertension
- ☐ 靜脈曲張 Varicosities/Phlebitis
- ☐ 甲狀腺 Thyroid/Dysfunction
- ☐ 糖尿病 Diabetes
- ☐ 自體免疫系統疾病 Autoimmune Disorder
- ☐ 腎臟和泌尿疾病 Kidney disease/UTI
- ☐ 白血病 Leukemia
- ☐ 肝病 Hepatitis/Liver Disease
- ☐ 季節性過敏 Seasonal Allergy
- ☐ 神經性疾病/癲癇 Neurologic/Epilepsy
- ☐ 憂鬱症 Depression/Postpartum Depression
- ☐ 暴力外傷 Trauma/Violence
- ☐ 輸血紀錄 History of Blood Transfusion
- ☐ 結核病或哮喘 Pulmonary (TB /Asthma)
- ☐ 麻醉併發症 Anesthetic Complications
- ☐ 乳房病史 Breast Disorder
- ☐ 子宮病變 Uterine anomaly/DES
- ☐ 不孕症 Infertility
- ☐ 子宮肌瘤 Fibroid
- ☐ 卵巢囊腫 Ovarian Cyst
- ☐ 不正常出血 Abnormal Uterine Bleeding
- ☐ 盆腔痛 Pelvic Pain
- ☐ 經痛 Dysmenorrhea
- ☐ 其他 Other:

_____

_____

_____

_____

_____

家族疾病史 Family History

親屬關係 Family Members	存/灭 Alive/Deceased	歲數 Age	糖尿病 Diabetes	高血壓 Hypertension	心臟病 Heart Disease	精神疾病 Mental Illness	癌症 Cancer	其他 Other
父親 Father	存/灭 Alive/Deceased							
母親 Mother	存/灭 Alive/Deceased							
配偶 Spouse	存/灭 Alive/Deceased							
手足 Siblings	存/灭 Alive/Deceased							
兒子 Sons	存/灭 Alive/Deceased							
女兒 Daughters	存/灭 Alive/Deceased							
祖父母 Grandparents	存/灭 Alive/Deceased							

基本體檢訊息 Physical

身高 Height:_____ 懷孕前體重 Pre-pregnancy weight:_____ 血壓 Blood Pressure:_____

病人簽名 Patient Signature: _____

Reviewer Signature_____

KRYSTAL H. PHAM, M.D., F.A.C.O.G.
DIPLOMATE, AMERICAN BOARD OF OBSTETRICS & GYNECOLOGY

We understand that medical information about you and your health is personal. As the custodians of the information in your record, we are committed to protecting the privacy of your information as required by law, professional accreditation stands and our internal policies and procedures.

Attached is your personal copy of our Notice of Privacy Practices. This notice explains your rights, our legal duties and our privacy practices. It also describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

For your convenience the following is a summary of the information discussed in the notice.

- Our Pledge
- Your Personal Information
- Our Privacy Practices
- How We May Use or Share Your Information for:
  - Treatment
  - Payment
  - Health Care Operations
  - Notifications
  - Marketing
  - Research
  - Special Circumstances and the Law
- Your Written permission
- Other restrictions
- Your Rights
- Changes
- Questions or Complaints

Please understand that this summary is not our Notice of Privacy Practices, nor is it a substitute for the notice. The actual notice should have been given to you, as required by law, with this cover letter. If it was not, Please contact our office manager at the address or phone number shown at the top of this page to receive your copy.

We ask that you sign and return this cover letter to us for our records. Your signature only acknowl- edges that we have provided you a personal, paper copy of our Notice of Privacy Practices as required by law. The law also required us to document the fact that we have distributed the notice by collecting and retaining these signed acknowledges.

If, after reviewing the notice, you decide that you do not want to retain your paper copy, please return it to our receptionist and we will recycle it.

I hereby acknowledge receipt of the Notice of Privacy Practices:

Signature:_____ **Printed Name:**_____ **Date**____/___/_____
簽名 拼音 日期 月 日 年

Miracle Orchids Medical
CENTER

KRYSTAL H. PHAM, M.D., F.A.C.O.G.
DIPLOMATE, AMERICAN BOARD OF
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Email: admin@miracleorchids.com

PHOTO RELEASE FORM

I hereby grant Miracle Orchids Medical Center OBGYN (Office of Dr. Krystal Pham) permission to use my likeness in a photograph, video, or other digital media ("photo") in any and all of its publications, including web-based publications, without payment or other consideration.

I understand and agree that all photos will become the property of Miracle Orchids Medical Center and will not be returned.

I hereby irrevocably authorize Miracle Orchids Medical Center to edit, alter, copy, exhibit, publish, or distribute these photos for any lawful purpose. In addition, I waive any right to inspect or approve the finished product wherein my likeness appears. Additionally, I waive any right to royalties or other compensation arising or related to the use of the photo.

I hereby hold harmless, release, and forever discharge Miracle Orchids Medical Center from all claims, demands, and causes of action which I, my heirs, representatives, executors, administrators, or any other persons acting on my behalf or on behalf of my estate have or may have by reason of this authorization.

I HAVE READ AND UNDERSTAND THE ABOVE PHIOTO RELEASE. I AFFIRM THAT I AM AT LEAST 18 YEARS OF AGE, OR, IF I AM UNDER 18 YEARS OF AGE, I HAVE OBTAINED THE REQUIRED CONSENT OF MY PARENTS/GUARDIANS AS EVIDENCED BY THEIR SIGNATURES BELOW. I ACCEPT:

_____
Print Name

_____ _____
Signature Date

If under 18, BOTH PARENTS MUST SIGN

_____ _____
Individually and as Parent and/ Date
Legal Guardian

_____ _____
Individually and as Parent and/ Date
Legal Guardian

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照片使用授權書

_____(以下簡稱授權人) 同意 Miracle Orchids Medical Center (以下簡稱被授權單位)，得使用授權影像於醫療診所網站與廣告專案之宣傳、相關印刷品製作及光碟或數位化方式重製。

詳細內容如下：

一、 影像授權範圍僅限醫療診所網站與廣告專案使用。

二、 授權人所提供之照片應無著作權爭議，
如有任何爭議應由授權人負責。

特此證明

授權人簽名：_____

授權人出生日期: _____

被授權人：Miracle Orchids Medical Center