

## Pre-employment Medical Questionnaire

## 入職前驗身健康調查問卷

Date 日期 : \_\_\_\_\_

Do you have allergy of any kind(s)?

\* No / Yes, details: ( )

閣下是否有任何敏感症?

\*沒有 / 有，請詳述： [ ]

**\* Please deletes as appropriate**

**\*請刪去不適用者**

Have you ever had any operation(s)?

\* No / Yes, details: ( )

閣下曾否接受任何手術?

\*沒有 / 有，請詳述： [ ]

Are you on regular medication(s)?

\* No / Yes, details: ( )

閣下是否有定期服用藥物?

\*沒有 / 有，請詳述： [ ]

Have you been addicted to any drug(s)?

\* No / Yes, details: ( )

閣下曾否對任何藥物上癮?

\*沒有 / 有，請詳述： [ ]

Do you smoke?

\* No / Yes: ( ) per day )

閣下有否吸煙?

\*沒有 / 有，詳情： [ 每日 枝 / 包 ]

Do you drink regularly?

\* No / Yes: ( ) per day )

閣下有否慣性地飲酒?

\*沒有 / 有，詳情： [ 每日 杯 ]

**Do you have any of the following medical history:**

**閣下有否下列病歷：**

Diabetes 糖尿病

Hypertension 高血壓

Heart Disease 心臟病

Lung Disease 肺疾病

Tuberculosis 肺癆病

Asthma 哮喘

Anaemia 貧血

Kidney Disease 腎病

Liver Disease 肝病

Epilepsy 羊癇症

Mental Illness 精神病

Cancer 癌症

Venereal Disease 性病

AIDS 愛滋病

HIV-positive HIV抗體陽性反應

\* Nil / Yes, please elaborate on any positive finding(s): ( )

\*沒有 / 有，請詳述： [ ]

**Do your parents and members of your family have any of the following:**

**閣下之父母及家庭成員有否下列病症:**

Diabetes 糖尿病	Hypertension 高血壓	Heart Disease 心臟病
Tuberculosis 肺癆病	Asthma 哮喘	Epilepsy 羊癇症
Mental Illness 精神病	Cancer 癌症	

\* Nil / Yes, please elaborate on any positive finding(s): ( )

\*沒有 / 有, 請詳述: [ ]

**Do you have any of the following symptoms currently:**

**閣下近來有否下列病徵:**

Headache 頭痛	Dizziness 頭暈	Smelling Loss 嗅覺減弱
Nose Bleeding 流鼻血	Deafness 耳聾	Swallowing Difficulty 吞嚥困難
Cough 咳嗽	Phlegm 多痰	Spitting Blood 咳血
Chest Pain 胸口疼痛	Shortness of Breath 氣喘	Stomach Pain 胃痛
Foot Swelling 腳腫	Weight Loss 體重驟輕	Blood in Stool 大便出血
Difficult in Passing Water 小便困難		

\* Nil / Yes, please elaborate on any positive finding(s): ( )

\*沒有 / 有, 請詳述: [ ]

**\*\* The following questions are for ladies only \*\***

**\*\* 下列問題只供女士作答 \*\***

Do you have any gynaecological symptoms?

\* No / Yes, details: ( )

閣下是否有任何婦科病徵?

\*沒有 / 有, 請詳述: [ ]

Are you pregnant?

\* No / Yes (The \_\_\_\_\_ week of pregnancy)

閣下是否正在懷孕?

\*否 / 是: [ 懷孕第 \_\_\_\_\_ 週 ]

When was the first day of your last menstrual period?

\_\_\_\_ / \_\_\_\_ / 200\_\_\_\_

閣下上一次月經的第一天是何時?

200\_\_年 月 日

I confirm that the information given above is correct to the best of my knowledge and I understand any falsification or misrepresentation in this form shall result in termination of my employment with the employer / company or its representatives that sent me for this medical examination without prior notice or payment in lieu of notice. I hereby authorize your medical practice, or its medical and nursing personnel to give full particulars of the results of this medical examination, including prior medical history, to the employer / company or its representatives.

A copy of this authorization shall be valid as the original.

本人証實上述一切均為真確。

如有虛報, 本人願受解僱處分而僱主/公司毋須給予預先通知或代通知金。

本人謹授權貴醫務所及其醫護人員, 將一切有關本人是次身體檢查之部份或全部紀錄及醫療往歷, 提供予派本人來此接受體格檢查之僱主/公司或其代表。

本人明白此授權書之影印本與正本功能無異。

Witness's Signature ( ) Patient's Signature ( )

見證人簽名 病人簽名

Witness's Name ( ) Patient's Name ( )

見證人姓名 病人姓名