Medical Questionnaire 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: 〔 〕

ＰＴＯ... 請轉後頁...

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?
____ / ____ / 20____
閣下上一次月經的第一天是何時?
20 ____年 月 日

I confirm that the information given above is correct to the best of my knowledge. I hereby authorize TY Medical Practice, or its medical and nursing personnel to give full particulars of the results of this physical examination, including prior medical history, to the Company.
A copy of this authorization shall be valid as the original.
本人証實上述一切均爲真確。
本人謹授權天一醫務所之醫護人員，將一切有關本人之部份或全部健康紀錄及治病詳情，提供予派本人來此接受體格檢查之公司或其代表。
本人明白此授權書之影印本與正本功能無異。

Signature 簽名 ( )

Name 姓名 ( )