MITMedical
Care for our community

患者健康史/Patient Health History

患者姓名/Patient name: ____________________
病历编号/MRN: ____________________
出生日期/DOB: ____________________
日期/Date: ____________________

就诊原因/您想咨询的内容/Reason for Visit/What do you want to talk about: ____________________

____

____

1. 患者病史/PATIENT HISTORY

您曾经或现在是否有以下任何问题？/Have you ever, or do you now have any of the following?

□ 贫血/anemia
□ 厌食/anorexia
□ 关节炎/arthritis
□ 哮喘/asthma
□ 癌症/cancer
□ 水痘/chicken pox
□ 饮食障碍/eating problems
□ 抑郁/depression
□ 糖尿病/diabetes
□ 癫痫/epilepsy or seizures
□ 心脏病/heart disease
□ 高/低血压/high/low blood pressure
□ 黑素瘤/melanoma
□ 月经紊乱/menstrual problems
□ 偏头痛/migraines
□ 性传播疾病/sexually transmitted disease
□ 甲状腺问题/thyroid problems
□ 其他，请列出/other, please list: ____________________

请列出所有住院治疗经历（外科、内科、精神科）及年份/Please list all hospitalizations you have had (surgical, medical, psychiatric) and the year: ____________________

____

____

2. 家族史/FAMILY HISTORY

如果回答“是”，请选择所有适用项/If yes, check all that apply:

乳腺癌/Breast Cancer	□ 否/no	□ 是/yes	□ 父亲/father	□ 母亲/mother	□ 兄弟姐妹/sibling	□ 其他血亲/other blood relative
结肠癌/Colon Cancer	□ 否/no	□ 是/yes	□ 父亲/father	□ 母亲/mother	□ 兄弟姐妹/sibling	□ 其他血亲/other blood relative
糖尿病/Diabetes	□ 否/no	□ 是/yes	□ 父亲/father	□ 母亲/mother	□ 兄弟姐妹/sibling	□ 其他血亲/other blood relative
遗传缺陷/Genetic Disorder	□ 否/no	□ 是/yes	□ 父亲/father	□ 母亲/mother	□ 兄弟姐妹/sibling	□ 其他血亲/other blood relative
心脏病/Heart Disease	□ 否/no	□ 是/yes	□ 父亲/father	□ 母亲/mother	□ 兄弟姐妹/sibling	□ 其他血亲/other blood relative
高血压/High Blood Pressure	□ 否/no	□ 是/yes	□ 父亲/father	□ 母亲/mother	□ 兄弟姐妹/sibling	□ 其他血亲/other blood relative
高胆固醇/High Cholesterol	□ 否/no	□ 是/yes	□ 父亲/father	□ 母亲/mother	□ 兄弟姐妹/sibling	□ 其他血亲/other blood relative
其他癌症/Other Cancer	□ 否/no	□ 是/yes	□ 父亲/father	□ 母亲/mother	□ 兄弟姐妹/sibling	□ 其他血亲/other blood relative

3. 健康风险评估/HEALTH RISK ASSESSMENT

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您是否饮酒？/Do you drink alcohol? □ 否/no □ 是/yes
如果回答"是"，每周几次/If yes, # of drinks per week:__________

您是否吸烟或者使用其他烟草制品？/Do you smoke or use other forms of tobacco? □ 否/no □ 是/yes □ 以前吸烟/former
如果以前吸烟，请填写戒烟日期/If former, quit date:__________

您是否曾使用娱乐/街头毒品？/Have you ever used recreational/street drugs? □ 否/no □ 是/yes

您是否曾滥用处方药？/Have you ever misused prescribed drugs? □ 否/no □ 是/yes

您是否经常锻炼？/Do you exercise regularly? □ 否/no □ 是/yes

您对自己的饮食习惯是否满意？/Are you satisfied with your eating habits? □ 否/no □ 是/yes

在过去的两周内，您有多长时间会感觉没有兴趣或乐趣做事情？请选择一个答案。/Over the past two weeks, how often have you had little interest or pleasure in doing things? Select one response.

□ 完全没有/not at all □ 几天/several days □ 一半以上时间/more than half of the days □ 几乎每天/nearly every day

在过去的两周内，您有多长时间会感觉情绪低落、抑郁或绝望？请选择一个答案。/Over the past two weeks, how often have you been down, depressed, or hopeless? Select one response.

□ 完全没有/not at all □ 几天/several days □ 一半以上时间/more than half of the days □ 几乎每天/nearly every day

是否有影响家人/对您很重要的人的重大问题？/Are there any significant issues affecting family/significant others? □ 否/no □ 是/yes
如果回答"是"，请说明/If yes, please explain:

关于您的医疗护理，是否有宗教/文化方面的注意事项？/Are there any religious/cultural considerations regarding your care? □ 否/no □ 是/yes
如果回答"是"，请说明/If yes, please explain:

您对性传播疾病是否有疑问？/Do you have any questions about sexually transmitted diseases? □ 否/no □ 是/yes

您愿意进行性传播疾病检查吗？/Would you like to be tested for sexually transmitted diseases? □ 否/no □ 是/yes

在学校和/或家里是否有任何经历让您感觉不安全？/Are you having any experiences on campus and/or at home that make you feel unsafe? □ 否/no □ 是/yes

4. 过敏和免疫接种/ALLERGIES and IMMUNIZATIONS

除非您有 Follow My Health 帐户，并且您已经检查和确认帐户中信息的准确性，否则请填写第 4 节 A-B 项。/Please complete section 4 A-B ***unless*** you have a Follow My Health account and you have reviewed and verified the accuracy of the information in your account.

如需了解关于 Follow My Health 的更多信息，请访问 medical.mit.edu/fmh/For more information on Follow My Health, please visit medical.mit.edu/fmh

A. 过敏/Allergies

您是否对药物过敏？/Do you have any allergies to medications? □ 否/no □ 是/yes
如果回答"是"，请列出药物和过敏反应/If yes, please list medication(s) and reaction: ______________________

____

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日期/Date: _________________________________

B. **免疫接种/Immunizations**

**就诊时，请携带所有免疫接种资料。/*Please bring any immunization information with you to your appointment.*

C. **药物/Medications**

**就诊时，请携带所有用药资料。/*Please bring any medication information with you to your appointment.*

5. 学习需求评估/LEARNING NEEDS ASSESSMENT

您是否有以下问题/Do you have any of the following:

学习障碍/Learning disabilities?	□ 否/no	□ 是/yes
视力受限/Visual limitations?	□ 否/no	□ 是/yes
听力受限/Hearing limitations?	□ 否/no	□ 是/yes

如果回答"是"，请说明/If yes, please explain: ____

____

____

6. 系统检查/REVIEW OF SYSTEMS

您目前是否正在经历以下问题？/Are you currently experiencing any of the following....?

a. 一般性问题/General

□ 疲劳/Fatigue □ 睡眠问题/Trouble sleeping □ 体重变化/Weight changes □ 虚弱/Weakness □ 发热/Fever

□ 疼痛，以 0 – 10 评分（0 = 没有疼痛，10 = 最严重疼痛）/Pain, rated on a scale from 0 - 10 (0 = no pain, 10 = worst pain):__________________

b. 功能评估/Functional assessment

您的健康状况是否限制您进行以下活动/Is your health limited in any of the following activities:

工作/Work?	□ 否/no	□ 是/yes	中等强度运动/Moderate exercise?	□ 否/no	□ 是/yes
日常杂务/Daily chores?	□ 否/no	□ 是/yes	高强度运动/Vigorous exercise?	□ 否/no	□ 是/yes

如果回答"是"，请说明/If yes, please explain: ____

c. 皮肤/Skin

□ 皮疹/Rashes □ 瘙痒/Itching □ 颜色变化/Color changes □ 肿块/Lumps □ 干燥/Dryness □ 毛发和指甲变化/Hair and nail changes

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日期/Date: ___________________________________

d. 头/Head

- ☐ 头痛/Headache
- ☐ 头部受伤/Head injury

e. 耳/Ears

- ☐ 耳痛/Earache
- ☐ 耳鸣/Tinnitus
- ☐ 引流/Drainage
- ☐ 听力减退/Decreased hearing

f. 眼/Eyes

- ☐ 视力/Vision
- ☐ 闪光/Flashing lights
- ☐ 白内障/Cataracts
- ☐ 眼镜/隐形眼镜/Glasses/contacts
- ☐ 模糊或双影/Blurry or double vision
- ☐ 疼痛/Pain
- ☐ 斑点/Specks
- ☐ 发红/Redness
- ☐ 青光眼/Glaucoma
- ☐ 上次眼部检查/Last eye exam:__________

g. 鼻/Nose

- ☐ 瘙痒/Itching
- ☐ 鼻出血/Nosebleeds
- ☐ 鼻塞/Stuffiness
- ☐ 分泌物/Discharge
- ☐ 花粉热/Hay fever
- ☐ 鼻痛/Sinus pain

h. 咽喉/口腔/Throat/ Mouth

- ☐ 牙齿/Teeth
- ☐ 舌痛/Sore tongue
- ☐ 鹅口疮/Thrush
- ☐ 牙龈问题/Gums
- ☐ 口干/Dry mouth
- ☐ 未愈合溃疡/Non-healing sores
- ☐ 出血/Bleeding
- ☐ 咽喉痛/Sore throat
- ☐ 义齿/Dentures
- ☐ 声音嘶哑/Hoarseness
- ☐ 上次口腔检查/Last dental exam: _________

i. 颈部/Neck

- ☐ 肿块/Lumps
- ☐ 疼痛/Pain
- ☐ 腺体肿胀/Swollen glands
- ☐ 僵硬/Stiffness

j. 乳房/Breasts

- ☐ 肿块/Lumps
- ☐ 分泌物/Discharge
- ☐ 哺乳/Breastfeeding
- ☐ 疼痛/Pain

k. 呼吸系统/Respiratory

- ☐ 咳嗽/Cough
- ☐ 咳血/Coughing up blood
- ☐ 哮喘/Wheezing
- ☐ 黏液/Mucus
- ☐ 呼吸短促/Shortness of breath
- ☐ 呼吸疼痛/Painful breathing

l. 心血管系统/Cardiovascular

- ☐ 胸部疼痛或不适/Chest pain or discomfort
- ☐ 躺下时呼吸困难/Difficulty breathing lying down
- ☐ 憋闷/Tightness
- ☐ 心悸/Palpitations
- ☐ 突然从睡眠中醒来并伴有呼吸短促/Sudden awakening from sleep with shortness of breath
- ☐ 活动时呼吸短促/Shortness of breath with activity
- ☐ 肿胀/Swelling

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m. 肠胃系统/Gastrointestinal

- ◻ 腹泻/Diarrhea
- ◻ 便秘/Constipation
- ◻ 胃口变化/Change in appetite
- ◻ 恶心/Nausea
- ◻ 眼睛或皮肤发黄（黄疸）/Yellow eyes or skin (jaundice)
- ◻ 排便习惯变化/Change in bowel habits
- ◻ 胃灼热/Heartburn
- ◻ 直肠出血/Rectal bleeding
- ◻ 吞咽困难/Swallowing difficulties

n. 泌尿系统/Urinary

- ◻ 尿频/Increased frequency
- ◻ 尿失禁/Loss of control of urine
- ◻ 排尿力量变化/Change in urinary strength
- ◻ 尿急/Urgency
- ◻ 排尿疼痛/Burning or pain
- ◻ 尿中带血（血尿）/Blood in urine (hematuria)

o. 生殖系统/Genital

男性/Male

- ◻ 疝气/Hernia
- ◻ 性行为时疼痛/Pain with sex
- ◻ 生殖器溃疡/Genital sores
- ◻ 阴茎分泌物/Penile discharge
- ◻ 勃起功能障碍/Erectile dysfunction
- ◻ 性传播疾病/STD's: ______________________
- ◻ 阴囊肿块或疼痛/Scrotal masses or pain

女性/Female

- ◻ 性行为时疼痛/Pain with sex
- ◻ 热潮红/Hot flashes
- ◻ 阴道瘙痒或皮疹/Vaginal itching or rash
- ◻ 阴道干燥/Vaginal dryness
- ◻ 阴道分泌物/Vaginal discharge
- ◻ 性病/STD's: ______________________
- ◻ 上次月经日期/Last menstrual period: __________
- ◻ 生殖器溃疡/Genital sores

p. 血管/Vascular

- ◻ 行走时小腿疼痛/Calf pain with walking
- ◻ 腿部肌肉痉挛/Leg cramping

q. 肌肉和骨骼/Musculoskeletal

- ◻ 背部疼痛/Back pain
- ◻ 僵硬/Stiffness
- ◻ 关节肿胀/Swelling of joints
- ◻ 外伤/Trauma
- ◻ 关节发红/Redness of joints
- ◻ 肌肉或关节疼痛/Muscle or joint pain

r. 神经系统/Neurologic

- ◻ 头晕/Dizziness
- ◻ 虚弱/Weakness
- ◻ 麻木/Numbness
- ◻ 震颤/Tremor
- ◻ 癫痫/Seizures
- ◻ 刺痛/Tingling
- ◻ 昏厥/Fainting

s. 血液系统/Hematologic

- ◻ 容易淤血/Ease of bruising
- ◻ 容易出血/Ease of bleeding

t. 内分泌系统/Endocrine

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□ 畏热或畏寒/Heat or cold intolerance □ 尿频/Frequent urination □ 多汗/Sweating □ 口渴/Thirst □ 胃口变化/Change in appetite

u. 精神/Psychiatric

□ 压力/Stress □ 健忘/Memory loss □ 神经质/Nervousness □ 抑郁/Depression

MIT 医疗中心重视 MIT 社区中每个人的健康和幸福。我们向您提出以下建议：/MIT The health and wellness of everyone in the MIT community is important to us at MIT Medical. We recommend the following:

- 在性行为中使用避孕套，以降低患性病和意外怀孕的风险/Condom use during sexual activity to reduce the risk of STDs and unintended pregnancy
- 使用汽车安全带，以降低受伤或死亡的风险，这是马萨诸塞州的法律规定/Use of automobile safety belts to reduce the risk of injury or death, which is the law in Massachusetts
- 进行自行车、轮滑、滑板等运动时佩戴头盔，以降低受伤的风险/Use of helmets while bicycling, rollerblading, skate boarding, etc. to reduce the risk of injury
- 在家里安装烟雾探测器，以降低火灾造成伤害或损失的风险/Home smoke detectors to reduce the risk of injury or damage from a fire
- 当您和孩子在户外阳光下时，请涂抹 SPF 15 或更高的防晒霜/Use of sunscreen SPF 15 or higher for you and your children when in the outdoor sun

患者姓名（打印）/Patient Name (PRINT): ______________________________ 出生日期/DOB:__________________

患者签名/Patient Signature: ____ 日期/Date: ______________________

医生签名/Provider Signature: ____ 日期/Date: ______________________

OCT-06-2014 /
2014 年 10 月 6 日