MITMedical
Care for our community

患者健康史/Patient Health History

患者姓名/Patient name:_____
病歷編號/MRN: _____
出生日期/DOB: _____
日期/Date: _____

就診原因/您想諮詢的內容/Reason for Visit/What do you want to talk about: _____

_____

_____

1. 患者病史/PATIENT HISTORY

您曾經或現在是否有以下任何問題？/Have you ever, or do you now have any of the following?

□ 貧血/anemia	□ 飲食障礙/eating problems	□ 黑素瘤/melanoma
□ 厭食/anorexia	□ 抑鬱/depression	□ 月經紊亂/menstrual problems
□ 關節炎/arthritis	□ 糖尿病/diabetes	□ 偏頭痛/migraines
□ 哮喘/asthma	□ 癲癇/epilepsy or seizures	□ 性傳播疾病/sexually transmitted disease
□ 癌症/cancer	□ 心臟病/heart disease	□ 甲狀腺問題/thyroid problems
□ 水痘/chicken pox	□ 高/低血壓/high/low blood pressure	□ 其他，請列出/other, please list: __ _____

請列出所有住院治療經歷（外科、內科、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」，請選擇所有適用項/If yes, check all that apply:

乳腺癌/Breast Cancer	□ 否/no □ 是/yes	□ 父親/father □ 母親/mother	□ 兄弟姐妹/sibling	□ 其他血親/other blood relative
結腸癌/Colon Cancer	□ 否/no □ 是/yes	□ 父親/father □ 母親/mother	□ 兄弟姐妹/sibling	□ 其他血親/other blood relative
糖尿病/Diabetes	□ 否/no □ 是/yes	□ 父親/father □ 母親/mother	□ 兄弟姐妹/sibling	□ 其他血親/other blood relative
遺傳缺陷/Genetic Disorder	□ 否/no □ 是/yes	□ 父親/father □ 母親/mother	□ 兄弟姐妹/sibling	□ 其他血親/other blood relative
心臟病/Heart Disease	□ 否/no □ 是/yes	□ 父親/father □ 母親/mother	□ 兄弟姐妹/sibling	□ 其他血親/other blood relative
高血壓/High Blood Pressure	□ 否/no □ 是/yes	□ 父親/father □ 母親/mother	□ 兄弟姐妹/sibling	□ 其他血親/other blood relative
高膽固醇/High Cholesterol	□ 否/no □ 是/yes	□ 父親/father □ 母親/mother	□ 兄弟姐妹/sibling	□ 其他血親/other blood relative
其他癌症/Other Cancer	□ 否/no □ 是/yes	□ 父親/father □ 母親/mother	□ 兄弟姐妹/sibling	□ 其他血親/other blood relative

3. 健康風險評估/HEALTH RISK ASSESSMENT

您是否飲酒？/Do you drink alcohol? □ 否/no □ 是/yes

如果回答「是」，每週幾次/If yes, # of drinks per week:_____

Go to Next Page/轉至下一頁

MITMedical
Care for our community

患者健康史（續）/Patient Health History, cont'd

患者姓名/Patient name:_____
病歷編號/MRN: _____
出生日期/DOB: _____
日期/Date: _____

您是否吸煙或者使用其他煙草製品？/Do you smoke or use other forms of tobacco?	□ 否/no	□ 是/yes	□ 以前吸煙/former
如果以前吸煙，請填寫戒煙日期/If former, quit date:_____			
您是否曾使用娛樂/街頭毒品？/Have you ever used recreational/street drugs?	□ 否/no	□ 是/yes	
您是否曾濫用處方藥？/Have you ever misused prescribed drugs?	□ 否/no	□ 是/yes	
您是否經常鍛煉？/Do you exercise regularly?	□ 否/no	□ 是/yes	
您對自己的飲食習慣是否滿意？/Are you satisfied with your eating habits?	□ 否/no	□ 是/yes	

在過去的兩週內，您有多長時間會感覺沒有興趣或樂趣做事情？請選擇一個答案。/Over the past two weeks, how often have you had little interest or pleasure in doing things? Select one response.

□ 完全沒有/not at all □ 幾天/several days □ 一半以上時間/more than half of the days □ 幾乎每天/nearly every day

在過去的兩週內，您有多長時間會感覺情緒低落、抑鬱或絕望？請選擇一個答案。/Over the past two weeks, how often have you been down, depressed, or hopeless? Select one response.

□ 完全沒有/not at all □ 幾天/several days □ 一半以上時間/more than half of the days □ 幾乎每天/nearly every day

是否有影響家人/對您很重要的人的重大問題？/Are there any significant issues affecting family/significant others?	□ 否/no	□ 是/yes
如果回答「是」，請說明/If yes, please explain:		
關於您的醫療護理，是否有宗教/文化方面的注意事項？/Are there any religious/cultural considerations regarding your care?	□ 否/no	□ 是/yes
如果回答「是」，請說明/If yes, please explain:		
您對性傳播疾病是否有疑問？/Do you have any questions about sexually transmitted diseases?	□ 否/no	□ 是/yes
您願意進行性傳播疾病檢查嗎？/Would you like to be tested for sexually transmitted diseases?	□ 否/no	□ 是/yes
在學校和/或家裡是否有任何經歷讓您感覺不安全？/Are you having any experiences on campus and/or at home that make you feel unsafe?	□ 否/no	□ 是/yes

4. 過敏和免疫接種/ALLERGIES and IMMUNIZATIONS

除非您有 Follow My Health 帳戶，並且您已經檢查及確認帳戶中資訊的準確性，否則請填寫第 4 節 A-B 項。/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.

如需瞭解關於 Follow My Health 的更多資訊，請瀏覽 medical.mit.edu/fmh/For more information on Follow My Health, please visit medical.mit.edu/fmh

A. 過敏/Allergies

您是否對藥物過敏？/Do you have any allergies to medications?	□ 否/no	□ 是/yes

如果回答「是」，請列出藥物和過敏反應/If yes, please list medication(s) and reaction: _____

_____

_____

Go to Next Page/轉至下一頁

MITMedical
Care for our community

患者健康史（續）/Patient Health History, cont'd

患者姓名/Patient name:_____
病歷編號/MRN: _____
出生日期/DOB: _____
日期/Date: _____

B. **免疫接種/Immunizations**

就診時，請攜帶所有免疫接種資料。/Please bring any immunization information with you to your appointment.*

C. **藥物/Medications**

就診時，請攜帶所有用藥資料。/Please bring any medication information with you to your appointment.*

5. 學習需求評估/LEARNING NEEDS ASSESSMENT

您是否有以下問題/Do you have any of the following:

學習障礙/Learning disabilities?	□ 否/no	□ 是/yes
視力受限/Visual limitations?	□ 否/no	□ 是/yes
聽力受限/Hearing limitations?	□ 否/no	□ 是/yes

如果回答「是」，請說明/If yes, please explain: _____

_____

_____

6. 系統檢查/REVIEW OF SYSTEMS

您目前是否正在經歷以下問題？/Are you currently experiencing any of the following....?

a. 一般性問題/General

□ 疲勞/Fatigue □ 睡眠問題/Trouble sleeping □ 體重變化/Weight changes □ 虛弱/Weakness □ 發熱/Fever

□ 疼痛，以 0 – 10 評分（0 = 沒有疼痛，10 = 最嚴重疼痛）/Pain, rated on a scale from 0 - 10 (0 = no pain, 10 = worst pain):_____

b. 功能評估/Functional assessment

您的健康狀況是否限制您進行以下活動/Is your health limited in any of the following activities:

工作/Work?	□ 否/no	□ 是/yes	中等強度運動/Moderate exercise?	□ 否/no	□ 是/yes
日常雜務/Daily chores?	□ 否/no	□ 是/yes	高強度運動/Vigorous exercise?	□ 否/no	□ 是/yes

如果回答「是」，請說明/If yes, please explain: _____

c. 皮膚/Skin

□ 皮疹/Rashes □ 瘙癢/Itching □ 顏色變化/Color changes □ 腫塊/Lumps □ 乾燥/Dryness □ 毛髮和指甲變化/Hair and nail changes

d. 頭/Head

□ 頭痛/Headache □ 頭部受傷/Head injury

Go to Next Page/轉至下一頁

MITMedical
Care for our community

患者健康史（續）/Patient Health History, cont'd

患者姓名/Patient name:_____
病歷編號/MRN: _____
出生日期/DOB: _____
日期/Date: _____

e. 耳/Ears

□ 耳痛/Earache □ 耳鳴/Tinnitus □ 引流/Drainage □ 聽力減退/Decreased hearing

f. 眼/Eyes

□ 視力/Vision □ 閃光/Flashing lights □ 白內障/Cataracts □ 眼鏡/隱形眼鏡/Glasses/contacts □ 模糊或複視/Blurry or double vision

□ 疼痛/Pain □ 斑點/Specks □ 發紅/Redness □ 青光眼/Glaucoma □ 上次眼部檢查/Last eye exam:_____

g. 鼻/Nose

□ 瘙癢/Itching □ 鼻出血/Nosebleeds □ 鼻塞/Stuffiness □ 分泌物/Discharge □ 花粉熱/Hay fever □ 鼻痛/Sinus pain

h. 咽喉/口腔/Throat/ Mouth

□ 牙齒/Teeth □ 舌痛/Sore tongue □ 鵝口瘡/Thrush □ 牙齦問題/Gums □ 口乾/Dry mouth □ 未癒合潰瘍/Non-healing sores

□ 出血/Bleeding □ 咽喉痛/Sore throat □ 義齒/Dentures □ 聲音嘶啞/Hoarseness □ 上次口腔檢查/Last dental exam: _____

i. 頸部/Neck

□ 腫塊/Lumps □ 疼痛/Pain □ 腺體腫脹/Swollen glands □ 僵硬/Stiffness

j. 乳房/Breasts

□ 腫塊/Lumps □ 分泌物/Discharge □ 哺乳/Breastfeeding □ 疼痛/Pain

k. 呼吸系統/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. 心血管系統/Cardiovascular

□ 胸部疼痛或不適/Chest pain or discomfort □ 躺下時呼吸困難/Difficulty breathing lying down □ 憋悶/Tightness □ 心悸/Palpitations

□ 突然從睡眠中醒來並伴有呼吸短促/Sudden awakening from sleep with shortness of breath □ 活動時呼吸短促/Shortness of breath with activity □ 腫脹/Swelling

Go to Next Page/轉至下一頁

MITMedical
Care for our community

患者健康史（續）/Patient Health History, cont'd

患者姓名/Patient name:_____
病歷編號/MRN: _____
出生日期/DOB: _____
日期/Date: _____

m. 腸胃系統/Gastrointestinal

□ 腹瀉/Diarrhea □ 便秘/Constipation □ 食慾變化/Change in appetite □ 噁心/Nausea □ 眼睛或皮膚發黃（黃疸）/Yellow eyes or skin (jaundice) □ 排便習慣變化/Change in bowel habits

□ 胃灼熱/Heartburn □ 直腸出血/Rectal bleeding □ 吞嚥困難/Swallowing difficulties

n. 泌尿系統/Urinary

□ 尿頻/Increased frequency □ 尿失禁/Loss of control of urine □ 排尿力量變化/Change in urinary strength

□ 尿急/Urgency □ 排尿疼痛/Burning or pain □ 尿中帶血（血尿）/Blood in urine (hematuria)

o. 生殖系統/Genital

男性/Male

□ 疝氣/Hernia □ 性行為時疼痛/Pain with sex □ 生殖器潰瘍/Genital sores □ 陰莖分泌物/Penile discharge □ 勃起功能障礙/Erectile dysfunction

□ 性傳播疾病/STD's: _____ □ 陰囊腫塊或疼痛/Scrotal masses or pain

女性/Female

□ 性行為時疼痛/Pain with sex □ 熱潮紅/Hot flashes □ 陰道瘙癢或皮疹/Vaginal itching or rash □ 陰道乾燥/Vaginal dryness □ 陰道分泌物/Vaginal discharge

□ 性病/STD's: _____ □ 上次月經日期/Last menstrual period: _____ □ 生殖器潰瘍/Genital sores

p. 血管/Vascular

□ 行走時小腿疼痛/Calf pain with walking □ 腿部肌肉痙攣/Leg cramping

q. 肌肉和骨骼/Musculoskeletal

□ 背部疼痛/Back pain □ 僵硬/Stiffness □ 關節腫脹/Swelling of joints □ 外傷/Trauma □ 關節發紅/Redness of joints □ 肌肉或關節疼痛/Muscle or joint pain

r. 神經系統/Neurologic

□ 頭暈/Dizziness □ 虛弱/Weakness □ 麻木/Numbness □ 震顫/Tremor □ 癲癇/Seizures □ 刺痛/Tingling □ 昏厥/Fainting

s. 血液系統/Hematologic

□ 容易淤血/Ease of bruising □ 容易出血/Ease of bleeding

t. 內分泌系統/Endocrine

□ 畏熱或畏寒/Heat or cold intolerance □ 尿頻/Frequent urination □ 多汗/Sweating □ 口渴/Thirst □ 食慾變化/Change in appetite

u. 精神/Psychiatric

□ 壓力/Stress □ 健忘/Memory loss □ 神經質/Nervousness □ 抑鬱/Depression

Go to Next Page/轉至下一頁

MITMedical
Care for our community

患者健康史（續）/Patient Health History, cont'd

患者姓名/Patient name:_____
病歷編號/MRN: _____
出生日期/DOB: _____
日期/Date: _____

MIT 醫療中心重視 MIT 社區中每個人的健康和幸福。我們向您提出以下建議：/MIT The health and wellness of everyone in the MIT community is important to us at MIT Medical. We recommend the following:

- 在性行為中使用避孕套，以降低性傳播疾病和意外懷孕的風險/Condom use during sexual activity to reduce the risk of STDs and unintended pregnancy
- 使用汽車安全帶，以降低受傷或死亡的風險，這是麻塞諸塞州的法律規定/Use of automobile safety belts to reduce the risk of injury or death, which is the law in Massachusetts
- 進行自行車、輪滑、滑板等運動時佩戴頭盔，以降低受傷的風險/Use of helmets while bicycling, rollerblading, skate boarding, etc. to reduce the risk of injury
- 在家裡安裝煙霧探測器，以降低火災造成傷害或損失的風險/Home smoke detectors to reduce the risk of injury or damage from a fire
- 當您和孩子在戶外陽光下時，請塗抹 SPF 15 或更高的防曬霜/Use of sunscreen SPF 15 or higher for you and your children when in the outdoor sun

患者姓名（列印）/Patient Name (PRINT): _____ 出生日期/DOB:_____

患者簽名/Patient Signature: _____ 日期/Date: _____

醫生簽名/Provider Signature: _____ 日期/Date: _____