Dumrong Tangchitnob MD Inc and Its Affiliated Physicians
1135 S. Sunset Ave., Ste #102
West Covina, CA 91790
P: (626) 338-5377 | F: (626) 851-8822

Today's Date 今天日期: _____ Birthdate 出生日期: _____

Name 姓名: _____ Home Telephone # 電話號碼: ( ) _____

Age 年齡: _____ Race 種族: _____ Cell Phone # 手提號碼: ( ) _____

Address 地址: _____

City 城市: _____ Zip 郵政號碼: _____ Email 電子郵件: _____

Pharmacy Name 藥房名字: _____ Pharmacy Zip Code 藥房郵政號碼: _____

Insurance 保險 | Primary 主要: _____

Secondary 次要: _____

Patient SS# 社會安全號碼: _____ Insure SS# 保險 社會安全號碼: _____

Employer 雇主: _____ Phone # 電話號碼: ( ) _____

Business Address 公司地址: _____

Occupation 職業: _____ Name of Spouse 配偶姓名: _____

Name of Friend in Area 鄰近朋友姓名: _____ Telephone # 電話號碼: _____

Name of Relative 家人姓名: _____ Telephone # 電話號碼: _____

Name of Referring Person/Physician/PCP 介紹人/主診醫生: _____

Authorization 付款及披露健康信息授權書:

	是	否
1. I hereby authorize payment directly to above named physician of the surgical, medical benefits if any otherwise payable to me for his services as described on attached claim.	(Yes)	(No)
2. I realize that this may not represent a full payment for services rendered and I will be responsible for balance due that is not covered by my insurance.	(Yes)	(No)
3. I hereby authorize above named physician to release any information acquired the course of my examination or treatment.	(Yes)	(No)
4. I hereby authorize above named physician and his staffs to contact and telephone report medical information via phone.	(Yes)	(No)

Patient Signature 簽名: _____ Date 日期: _____

Receipt of Notice of Privacy Practices Written Acknowledgement Form 收到確認書

I hereby have received a copy of Dumrong Tangchitnob MD and Its Affiliated Physicians' Notice of Privacy Practice. 我已收到一份隱私權慣例做法通知副本。

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Patient Signature 簽名: _____ Date 日期: _____

Name 姓名: _____ Age 年齡: _____ ☐Married 已婚 ☐Single 單身

Family History 家族病歷:

	Age(s) 年齡	Health Status 健康狀況
Father 父親:		
Mother 母親:		
Brothers & Sisters: 兄弟姐妹		
Husband & Wife 丈夫/妻子:		
Children 孩子:		

Past Medical History 過去病史:

1. Medical History 病史: _____
2. Surgical History 手術史: _____
3. Pregnancy History 懷孕史:
   - How many children born alive 分娩次數: _____
   - How many stillborns 死產次數: _____
   - How many premature children 早產次數: _____
   - How many abortions 人工流產次數: _____
   - How many miscarriages 自然流產次數: _____

Did you have C-Section? 是否有剖腹產? ☐ Yes 是 ☐ No 否

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Symptoms: (Please mark if there are any symptoms listed below)
症狀:（如有下列任何症狀， 請註明)

	是	否
1. Any current weight loss or poor appetite 體重減少或食慾不良	☐Yes	☐No
2. Tiredness, weakness, fainting spell 疲倦，虛弱，昏厥	☐Yes	☐No
3. Abnormal visions, headache 視力異常，頭痛	☐Yes	☐No
4. Chest pain, heart palpitation 胸痛，心悸	☐Yes	☐No
5. Breathing difficulty 呼吸困難	☐Yes	☐No
6. Abdominal pain, bloating symptoms 腹痛，腹脹	☐Yes	☐No
7. Backache 背痛	☐Yes	☐No
8. Abnormal urination, leaking urination 排尿異常，失禁	☐Yes	☐No
9. Abnormal bowel movement (diarrhea, constipation, bloody stool) 排便異常（腹瀉，便秘，血便）	☐Yes	☐No
10. Hot flashes, depression, sleeping problem 潮熱，抑鬱，失眠	☐Yes	☐No
11. Weakness, loss of sensation of extremities 虛弱，四肢失去感覺	☐Yes	☐No
12. Abnormal menstruation 月經異常	☐Yes	☐No
13. Painful menstruation 經痛	☐Yes	☐No
14. Abnormal vaginal discharge 異常陰道分泌物	☐Yes	☐No

Allergy 過敏: Food 食物 _____

Drug 藥物 _____

Medication 服用藥物: _____

_____

Menstruation 月經: Age at onset 初潮年齡 _____

Regular 正常 ☐Yes 是 ☐No 否

Cycles 經期 _____ days 天 Lasts 持續 _____ Days 天

☐Heavy 多量 ☐Medium 中量 ☐Light 少量

First day of last period 末次月經的第一天 _____ ☐Normal 正常 ☐Abnormal 異常

Habit 習慣: ☐Alcohol 飲酒 ☐Smoking 抽煙 ☐Street drugs 毒品

Signature 簽名: _____ Date 日期: _____

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I, _____ give consent to Dr. Tangchitnob and office staff to relay any messages and information pertinent to my health to the following:
我 _____ 同意醫生 Dr. Tangchitnob 和職員向以下的人轉達任何與我的健康狀況相關的信息和資料。

Please cross the list that you do not want us to contact
請劃去您不希望我們聯繫的名單

1. Family members (spouse and children) 家庭成員（配偶與子女）
2. Friend and relatives 朋友與親戚
3. Employer(s) and co-worker(s) 雇主與同事
4. My answering machine 我的電話答錄機
5. My health insurance 我的健康保險
6. 其他 _____

Name 姓名: _____

Signature 簽名: _____

Date 日期: _____

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Incontinence Questions 排尿問題:	**有**	**沒有**
1. I have strong, sudden urges to urinate. 我會突然有強烈的尿意。	☐Yes	☐No
2. I go to the bathroom more than I used to (>8 times/day). 我去衛生間的次數較以前頻密（每天多於 8 次）。	☐Yes	☐No
3. I worry that sometimes I won't make it to the bathroom in time. 我會擔心有時候會來不及上廁所。	☐Yes	☐No
4. I go to the bathroom so often at night that it interferes with my sleep (2 or more times). 我經常晚上需要起來上廁所（2 次或以上），導致我的睡眠被干擾。	☐Yes	☐No
5. I loose urine when I sneeze, cough or jog. 在打噴嚏，咳嗽或跑步的時候， 我會有漏尿的情況。	☐Yes	☐No
6. I feel that I am not able to empty my bladder. 我覺得我無法完全把尿排乾淨。	☐Yes	☐No
7. I am not aware when I lose my urine. 我會在不知覺的情況下漏尿。	☐Yes	☐No

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Advance Directive Acknowledgement
預設醫療指示承認書

Dumrong Tangchitnob, MD., Inc. respects your right to self-determination in health care decision making. This facility will comply with all state and federal laws regarding the implementation of Advance Directives.

All of us at Dumrong Tangchitnob, MD., Inc. want our patients to understand their rights to make medical decisions. Dumrong Tangchitnob, MD., Inc. complies with California laws and court decisions on Advance Directives. We do not condition the provision of care or otherwise discriminate against anyone based on whether or not you have executed an Advanced Directive. We have formal policies to ensure that your wishes about treatment will be followed.

It is your responsibility to provide a copy of your Advance Directive to the hospital so that it can be kept with your records.

Please read and circle your answer
請閱讀並圈起您的答案

1. I have executed an Advance. 我有訂立預設醫療指示。	☐Yes ☐是	☐No ☐否
2. I have been given written materials about my rights. 我有收到關於我的權利書面材料。	☐Yes ☐是	☐No ☐否
3. I would like to receive additional information regarding Advance Directives. 我想要收到額外關於預設醫療指示的資訊。	☐Yes ☐是	☐No ☐否
4. I have received the additional information regarding Advance Directives. 我已經收到額外關於預設醫療指示的資訊。	☐Yes ☐是	☐No ☐否

Patient Signature 簽名: _____ Date 日期: _____

Comments 評論: _____

_____

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