Pearl W. Yee, M.D. Inc.
Obstetrics • Gynecology • Medical Aesthetics • Menopause • Prevention of Hereditary Cancer
Minimally Invasive and Robotic Gynecological Surgery

婦科調查表 Initial Intake Form

日期Date:_____/_____/_____ 年齡Age:_____

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

地址:_____

Address 街名 Street 城市 City 州 State 郵區號碼 Zip Code

_____ _____ _____

家庭電話 Home Phone# 手機電話 Cell Phone # 工作電話 Work Phone#

電子郵件 E-mail address:_____

家庭醫生Primary Care Physician:_____ 介紹人Referred by:_____

Is there anything you want to talk to your physician about? 有其他問題要詢問醫生嗎?_____

_____

Medications: (include over the counter)
藥物: (包括不用處方藥等)

Drug Names 藥名	Dosage 劑量

Allergies/Sensitivity: drugs, latex, environment, food
過敏/敏感: 藥物,乳膠, 圍繞物, 食物

Gynecological History 婦科歷史

Have you ever been treated for: 曾經有過的性病: Herpes 皰疹 Chlamydia 衣菌體 Gonorrhea 淋病
Genital Warts 花柳疣 Bacterial Vaginitis 細菌陰道炎 Trichomonas 滴蟲 Syphilis 梅毒

Have you had a Pap smear in the last 7 years? 這七年內有沒有做子宮頸抹片? No 沒有 Yes 有

Have you ever had an abnormal Pap smear? 有沒有不正常的子宮頸抹片? No 沒有 Yes有
When? 何時?_____ What Abnormality? 什麼不正常? _____

Are you currently sexually active? 有性生活嗎? No 沒有 Yes 有 Never 從來沒有
Did you begin sexual activity before 16 year old? 您在十六歲前有性行為嗎? No 沒有 Yes 有
If yes, Age started: 如有, 開始年齡: _____
Have you had > 5 sexual partners in your lifetime? 您有超過五位性伴侶嗎? No 沒有 Yes 有
Sexual Orientation: 性取向: Heterosexual 異性戀者 Lesbian 女同性戀者 Bi-Sexual 兩性者

Menstrual History or Menopausal Since: 月經歷史或停經的日期: _____
What is the first day of your last menstrual period? 最後一次月經期?_____
How long do your cycles last? 您的月經期來多少日?_____ How many days apart are your menstrual cycles starting from the first day of one cycle to the first day of your next cycle? 每隔多久來一次月經?
_____ What age did you start having menses? 月經期開始年齡?_____

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

Gynecological History 婦科歷史

Are you currently using birth control? 現在有沒有避孕?

No 沒有 Yes 有 Trying to get pregnant 嘗試懷孕

Are you taking birth control pills or any hormones? 有沒有服用避孕藥或者任何荷爾蒙藥?

No 沒有 Yes 有

Current birth control method used 現在避孕方法: _____

Are you satisfied with it? 滿意嗎? No 不滿意 Yes 滿意

Past birth control methods: 以前避孕方法:

Condoms 保險套 Birth control pills 避孕藥 Withdrawal 體外射精 Tubal Ligation 結紮

Diaphragm 子宮帽 Patch 避孕貼片 Rhythm 計日子 Vasectomy 輸精管切除

Vaginal Film 陰道薄膜 Vaginal Ring 陰道圈 IUD 子宮環 Essure 輸卵管植入物

Have you ever tested positive for HIV? 有沒有檢驗愛滋病? No 沒有 Yes 有

Did your mother take the drug DES (diethylstilbestrol) when she was pregnant with you? Unknown 不知道

您母親在懷孕時有沒有吃乙烯雌酚藥(人工合成的女性動情激素)? No 沒有 Yes 有

Pregnancy History 懷孕歷史

	Number 次數		Number 次數		Number 次數
Total time pregnant 受孕次數		Full term deliveries 足月分娩		Cesarean sections 剖腹分娩	
Miscarriages 流產		Deliveries before 37 wks 早產(少過三十七星期)		Forceps or vacuums 鑷子或吸取分娩	
Abortions 墮胎		Living children 生存孩子數目			
Describe any special pregnancy problems: 請敘述任何懷孕期問題:					

Personal Medical History 個人醫學歷史

Major Illnesses 主要疾病	Yes 有		Yes 有		Yes 有
Diabetes 糖尿病		Heart disease 心臟病/ MVP 心臟瓣膜脫垂		Anxiety 憂慮症	
High blood pressure 高血壓		High cholesterol 膽固醇		Depression 抑鬱症	
GI disease 腸胃病		Hepatitis 肝炎		Seizures 痙癇症(發痙癲)	
GI reflux disease腸胃逆流疾病		Liver problem 肝病		Asthma 哮喘	
Fibroids 纖維瘤		Kidney infections/stones 腎感染/腎結石		Lung disease 肺病	
Endometriosis 子宮內膜異位		Arthritis 關節炎		Tuberculosis 肺結核	
Osteopenia 骨質稀少		Joint pain 關節痛		Thyroid disease 甲狀腺病	
Osteoporosis 骨質疏鬆症		Fracture 骨折		Clotting problem 凝結問題	
Cancer (Breast/Ovary/Uterus/Colon/Etc.) 癌症 (乳房癌/卵巢癌/子宮癌/結腸癌/其他的癌症):					
Others 其他:					

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

Surgical History 外科手術歷史

Surgery 外科手術	Year 年份	Surgery 外科手術	Year 年份

Family History 家庭歷史

Major Illnesses 主要疾病	**Yes 有**		**Yes 有**		**Yes 有**
Diabetes 糖尿病		Heart disease 心臟病		Anxiety 憂慮症	
High blood pressure 高血壓		High cholesterol 膽固醇		Depression 抑鬱症	
GI disease 腸胃病		Hepatitis 肝炎		Seizures 痙攣症(發痒癲)	
GI reflux disease腸胃逆流疾病		Liver problem 肝病		Asthma 哮喘	
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Osteoporosis 骨質疏鬆症		Fracture 骨折		Clotting problem 凝結問題	

Family History of Cancer (Breast/Ovary/Uterus/Colon/Etc.)
家族癌症病歷 (乳房癌/卵巢癌/子宮癌/結腸癌/其他的癌症) :

Others 其他:

Social History 社會歷史

Personal Profile 個人簡介

Birth Place:_____
Ethnicity:_____
出生地方 種族

Marital status: Married 已婚 Divorced 離婚 Single 單身 Widowed 寡婦
婚姻狀況: Significantly Involved 親密伴侶 Domestic Partner 同性伴侶

School Completed: 學歷程度: High School 高中 College 大學 Graduate School 研究院 Other 其他
Occupation: 職業
:_____

Exercise: 有運動嗎? Yes 有 No 沒有 How often 次數
_____
Type: 那一類
_____
Special Diet: 特別飲食: Yes 有 No 沒有 Type 那一種
_____

Hobbies, Interests, Goals: 愛好, 興趣, 目標

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

Habits 習慣					
	有	沒有			
Smoking: 吸煙:	Yes	No	Packs/day_____ 一天幾包	Years_____ 幾年	Quit when:_____ 那一年停的:
Alcohol: 喝酒:	Yes	No	Drinks/day_____ 一天幾杯	Drinks/week_____ 一星期幾杯	Quit when:_____ 那一年停的:
Drug Use 用藥:	Yes	No	Type_____ 種類	Years_____ 幾年	Quit when:_____ 那一年停的:
Caffeine 咖啡因	Yes	No	Cups per day_____ 一天幾杯		Cups per week_____ 一星期幾杯
Do you own any pets? (If yes, what kind?) 您有沒有寵物? 那一類 _____					
Do you use seatbelts? 您用不用安全帶?			Yes 用	No 不用	
Do you use sunscreen? 您用不用防曬油?			Yes 用	No 不用	
Do you own guns in your home? 您的家裡有沒有存放槍械?				Yes 有	No 沒有
If yes, is it in a secure location? 如有, 是否存放在安全地方?					Yes 有 No 沒有

Personal Safety 個人安全		
有	沒有	
Yes	No	Has anyone close to you ever threatened to hurt you? 有沒有人威脅要傷害您?
Yes	No	Has anyone ever hit, kicked, choked or hurt you physically? 有沒有人打, 踢, 堵塞或身體傷害?
Yes	No	Has anyone, including you partner, ever forced you to have sex? 有沒有人, 包括您的伴侶,強迫與您發生性行為?
Yes	No	Are you ever afraid of your partner? 您怕您的伴侶嗎?

Review of Systems 復習系統

Please make Notes if you check symptoms 如有以下症狀,請符號(√)和註釋:

1. Constitutional 一般性		Notes 註釋	3. ENT/Mouth 耳鼻喉		Notes 註釋
Fever 發燒			Ear aches 耳痛		
Chills 發冷			Ringing in the ears 耳鳴		
Fatigue 疲勞			Sinus problems 靜脈竇管問題		
Weight loss 體重減輕			Sore throat 喉嚨痛		
Weight gain 體重增加			Mouth sores 口腔瘡		
2. Eyes 眼睛			Dry Mouth 口乾		
Change in vision 視力變化			4. Cardiovascular 心臟		
Double vision 雙重視力			Chest pain 胸口痛		

Name 姓名:_____ Birth Date 出生日期:_____/_____/_____

Difficulty breathing on exertion 呼吸問題		**Notes 註釋**	**8. Musculoskeletal** 肌肉		**Notes 註釋**
Swelling of legs 腿腫			Muscle weakness 肌肉無力		
Palpitations 心悸			Joint stiffness 關節僵硬		
Heart Murmurs 心臟雜音			Joint pain 關節痛		
5. Respiratory 呼吸			Joint swelling 關節腫		
Wheezing 喘息			**9. Skin/Breast** 皮膚/乳部		
Spitting up blood 吐血			Breast pain 乳部痛		
Shortness of breath 呼吸困難			Nipple discharge 乳頭排出物		
Cough 咳嗽			Breast lumps 乳部瘤		
6. Gastrointestinal 腸胃			Rash 皮疹		
Diarrhea 腹瀉			Ulcers 潰瘍		
Constipation 便秘			**10. Psychiatric** 精神病學		
Nausea/vomiting 噁心/嘔吐			Depression 抑鬱		
Bloody stool 便血			Mood swings 情緒波動		
Abdominal pain 肚子痛			Anxiety 憂慮		
Indigestion 消化不良			Suicidal thoughts 自殺心理		
Bloating 脹氣			Homicidal thoughts 殺人心理		
Liver problem/Hepatitis 肝病/肝炎			**11. Endocrine 內分泌**		
7. Genitourinary 生殖泌尿			Abnormal thirst 不正常口渴		
Blood in urine 血尿			Hot flashes 發熱		
Pain with urination 小便痛			Tremors 發抖		
Urgency 緊急			Cold/heat intolerance 受不了冷/熱		
Urinary Frequency 頻尿			**12. Hematologic** 血液/淋巴		
Urinary Incontinence 小便失禁			Frequent bruising 容易瘀傷		
Abnormal bleeding 不正常出血			Cuts do not stop bleeding 不容易停止流血		
Vaginal discharge/odor 陰道排出物/氣味			Enlarged lymph nodes 淋巴結腫大		
Vaginal itching/burning 陰道癢/痛			**13. Had blood transfusion? 輸血**		
Pelvic pain 骨盆痛			**14. Any antibiotics needed before dental work? 見牙科醫生前需服用抗生素嗎?**		
Menstrual cramps 月經痛			**15. How tall are you? 身高**		
Painful intercourse 性交痛					
Genital lump 生殖瘤					
Fertility concerns 受孕問題					
Menopausal concerns 更年期問題					

Please bring the above to the attention of your Primary Care Physician if not addressed today.
請提述以上的症狀給您的家庭醫生跟進.