SANTA CLARA
VALLEY MEDICAL CENTER
Hospital & Clinics

歡迎到腸胃和肝膽科診所!
WELCOME TO THE GASTROENTEROLOGY AND HEPATOLOGY CLINIC!

我們診所地點在:

Valley 專科中心 , 五樓 540 號房

Valley Specialty Center, 5th floor (Suite 540)

751 South Bascom Avenue

San Jose, CA 95128

電話: 408-793-2550
傳真: 408-885-7999

如果您需要取消或重新預約,
If you need to reschedule or cancel your appointment,

請至少在預約 24 小時前上網 *myHealth* 或來電取消
please call us or cancel via myHealth Online at least 24 hours before your appointment time

重要事項
IMPORTANT

請全部填完這份表格, 於門診時帶來
Please fill out this form completely and bring it with you to your appointment.

同時也將您所有目前使用的藥物, 包括成藥等,
連同原來的藥瓶, 一併帶來看診
Please also bring all your medications, including over the counter medications, in their original bottles.

您的姓名 Your name：

您的家庭醫師姓名與地址 Your primary care provider's name and address:

1. 什麼是您想要在看診時提出討論的最重要問題? What is the most important problem you wish to discuss in clinic?

2. 過敏：請列出藥物名稱及曾經發生過的過敏性反應症狀 。如果曾經對碘化物或放射科靜脈注射造影劑...等任何藥物產生過敏, 也請列出。Allergies: Please list name of medication and the reaction you have. Also list any allergies to iodine, radiology contrast, etc.

3. 檢查術與鎮定劑問題 Procedure and sedation issues

您是否曾經對麻醉劑或鎮定劑有嚴重反應(譬如術後醒不過來)? Have you ever had a bad reaction to anesthesia or sedation (such as trouble waking up afterwards)? O 是Y O 否 N

您是否曾在看完牙齒或動過其他檢查術後血流難止? Do you have a history of bleeding after dental work or other procedures? O 是Y O 否 N

您是否在家中使用輔助氧氣筒? Do you use supplemental oxygen at home? O 是Y O 否 N

您是否晚上睡覺使用機器幫助呼吸(譬如CPAP)? Do you use a machine to help you breathe at night (such as a CPAP machine)? O 是Y O 否 N

您是否嗑藥? (如果「是」請在第13項寫下毒品名稱)Do you use any recreational drugs? (please provide details in Section 13) O 是Y O 否 N

4. 藥物：請列出藥名, 劑量, 與每天使用次數。也請包括成藥名, 譬如 Tylenol (泰諾), Motrin, Aleve, ibuprofen（布洛芬), 制胃酸劑,.. 等 。 Medications: Please list names, doses, and number of times per day. Please include over-the counter medicines ..., etc.

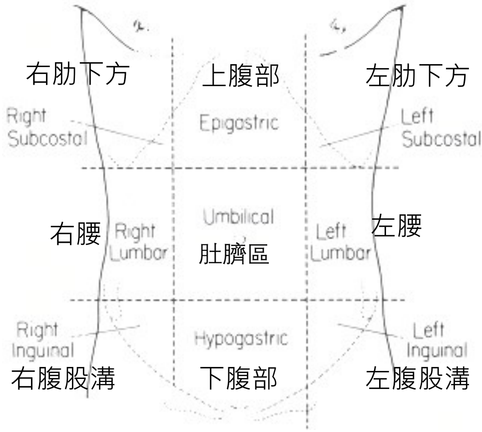
5. 您偏好的診所藥房取藥地點 (Preferred Pharmacy)

□ Valley 專科中心 (Valley Specialty Center)
□ Bascom
□ Downtown
□ East Valley
□ Gilroy
□ Lenzen
□ Milpitas
□ Moorpark
□ Sunnyvale
□ Tully

□ 其他 (請指明藥房名稱與地點) Other :______________________________

6. 您有腹痛嗎 (Do you have abdominal pain)?　O 是 Yes　O 否 (請跳到下一項做答) No

請在疼痛部位打「X」
Please indicate with an "X"
where the pain is located



每天平均有幾分痛?請按照 1 到 10 分的等級圈選
(On a scale of 1-10, how bad is the pain on an average day?)

1　2　3　4　5　6　7　8　9　10

請形容疼痛 (How would you describe the pain)? O 灼熱痛 (Burning) O 尖刺痛 (Stabbing) O 絞痛 (Cramping) O 酸痛 (Aching) O 其他(請說明) Other (specify) ________________

疼痛已經有多久 (How long have you had the pain)? ________________________________

多久痛一次 (How often do you get the pain)? ____________________________________

每次疼痛持續多久 (How long does the pain last)?

以下什麼事件會影響疼痛 (What affects the pain)?	較好 Better	較差 Worse	沒有改變 No change
吃東西(Eating)	O	O	O
大便(Bowel movement)	O	O	O
心理壓力(Stress)	O	O	O
制胃酸藥物(Antacids)	O	O	O
其他(請說明）Other (specify) ____________________	O	O	O

7. 您有任何下列其他腸胃症狀嗎?可以複選。Do you have any of these other GI symptoms? Please check all that apply.

O 吞嚥疼痛或困難 Difficult /painful swallowing
O 嘔心反胃 Nausea
O 嘔吐 Vomiting
O 心/胃灼熱(火燒心) Heartburn
O 多屁 Excessive passage of gas
O 胃脹氣 Bloating
O 便秘 Constipation
O 拉肚子 Diarrhea
O 大小便失禁 Incontinence/ leakage of stool
O 從直腸處出血 Blood from the rectum
O 吐血 Vomiting blood
O 大黑便 Black stools
O 黃疸(皮膚或眼白泛黃) Jaundice (yellow eyes or skin)
O 其他(請在下方說明) Other (specify below)

8. 之前腸胃評估 Prior GI Evaluation

曾經看過腸胃科醫生(胃,結腸,或肝科)嗎? Have you seen a gastroenterologist (stomach, colon, or liver specialist) in the past? O 有 Yes　O 沒有 No

如果有，請寫出腸胃科醫生名字和地址:
If Yes, name and address of gastroenterologist: ____

檢查術 Procedure	日期 Date	診所或醫院地點 Clinic or Hospital Location
胃鏡檢查 Upper endoscopy (EGD)		
大腸鏡檢查 Colonoscopy		
十二指腸鏡檢查 Sigmoidoscopy		
肝臟活檢 Liver Biopsy		
其他(請說明) Other (specify):		

9. 過去病史:請選出現在和過去曾經有過的健康問題 Past Medical History: please mark any medical problems you have had, past or present.

O 酗酒 Alcohol abuse
O 肛裂 Anal fissure
O 貧血 Anemia
O 關節炎 Arthritis
O 氣喘 Asthma
O 房顫 Atrial fibrillation
O 巴瑞特氏食道 Barrett's Esophagus
O 血凝塊(血栓) Blood clots
O 麩質過敏症 Celiac disease
O 便秘 Constipation
O 肝硬化 Cirrhosis
O 結(大)腸癌 Colon cancer
O 結(大)腸瘜肉 Colon polyps
O 局部性腸炎(克隆氏症) Crohn's Disease
O 憂鬱症/焦慮症 Depression/Anxiety
O 腹瀉 Diarrhea
O 糖尿病 Diabetes
O 憩室炎 Diverticulitis
O 憩室病 Diverticulosis
O 嗜酸性粒細胞食道炎 Eosinophilic esophagitis
O 食道靜脈曲張 Esophageal varices
O 脂肪肝 Fatty Liver
O 纖維肌痛症 Fibromyalgia
O 膽結石 Gallstones
O 幽門螺旋桿菌感染 H. pylori infection
O 頭痛 Headaches
O 心(胃)灼熱/火燒心 Heartburn
O 心病/心臟病/心臟支架 Heart disease/Heart attack/Heart stent
O 遺傳性血色素(鐵質)沈積症 Hemochromatosis
O 痔瘡 Hemorrhoids
O 乙(B)型肝炎 Hepatitis B
O 丙型(C)型肝炎Hepatitis C
O 肝炎 Hepatitis (請指明 specify_____________)
O 疝氣 Hernia (請指明 specify_____________)
O 橫膈膜疝(食道裂孔疝) Hiatal hernia
O 愛滋病毒或愛滋病 HIV or AIDS
O 免疫系統問題 Immune system problems
O 發炎性腸道疾病 Inflammatory Bowel Disease (IBD)
O 腸燥症 Irritable bowel syndrome (IBS)
O 腎病/腎衰竭 Kidney disease/renal failure
O 肝癌 Liver cancer
O 肺病/慢性阻塞性肺病 Lung disease/COPD
O 起搏器或去顫器 Pacemaker or Defibrillator
O 胰臟炎 Pancreatitis
O 胰臟癌 Pancreatic cancer
O 精神疾病/躁鬱症 Psychiatric disease/Bipolar disorder
O 睡眠呼吸中止症 Sleep apnea
O 胃/小腸潰瘍 Stomach/Intestinal ulcers
O 胃瘜肉 Stomach polyps
O 胃癌 Stomach cancer
O 中風 Stroke
O 甲狀腺問題 Thyroid problems
O 潰瘍性結(大)腸炎 Ulcerative Colitis
O 其他Other (請在下方說明 specify below)

10. 過去手術史 Past Surgical History

O 闌尾切除術 Appendectomy
O 腸塞術 Bowel obstruction surgery
O 剖腹產 C-section
O 結(大)腸手術 Colon surgery
O 食道手術 Esophagus surgery
O 胃造口術 Feeding tube placement (PEG)
O 膽囊手術 Gallbladder surgery
O 胃繞道術/減肥手術 Gastric bypass or banding
O 婦科手術 Gynecologic surgery
O 心臟繞道手術(搭橋) Heart bypass surgery
O 心脈瓣置換術 Heart valve surgery
O 疝氣修補術 Hernia repair
O 肝臟手術 Liver surgery
O 胰臟手術 Pancreas surgery
O 小腸手術 Small intestine surgery
O 胃手術 Stomach surgery
O 結紮手術 Tubal ligation
O 其他手術 Other surgery (請在下方說明)

11. 之前住院史 Prior hospitalizations: 請依序先從最近的日期開始列出 please list most recent ones first

日期 Date	醫院地點 Location	主訴 Problem

12. 家庭病史Family history: 請指出是否您的任何家庭成員曾經或目前有健康問題 Please indicate if any of your family members have or had any medical problems

	結腸癌 Colon cancer	結腸瘜肉 Colon polyps	胃癌 Stomach cancer	肝癌 Liver cancer	胰癌 Pancreas cancer	癌/生殖泌尿科癌 GYN / GU cancer 婦科	腸炎 Colitis/ IBD	麩質過敏 Celiac disease	肝病 Liver disease	幾歲被診斷出 Age at diagnosis	其他健康問題（請說明） Other medical problems (specify)	目前健在嗎? Currently alive?	去逝時的年紀 Age at death
父親 Father	O	O	O	O	O	O	O	O	O	________	____________________	O是Y O 否N	______
母親 Mother	O	O	O	O	O	O	O	O	O	________	____________________	O是Y O 否N	______
兄弟 Brother(s)	O	O	O	O	O	O	O	O	O	________	____________________	O是Y O 否N	______
姊妹 Sister(s)	O	O	O	O	O	O	O	O	O	________	____________________	O是Y O 否N	______
小孩 Children	O	O	O	O	O	O	O	O	O	________	____________________	O是Y O 否N	______
其他人Others	O	O	O	O	O	O	O	O	O	________	____________________	O是Y O 否N	______
(請指明 specify)													

13. 交際史 Social History

出生地 Place of birth ____________________________ 最近曾有任何美國境外旅遊? Any recent travel outside U.S.? O 是 Y O 否 N

菸酒毒品濫用 Substance use	目前 Current	以前 Former	從不 Never	開始日期 Date started	最近使用日期 Date of most recent use	多久用一次? How often do you use?	每次用多少? How much do you use?	準備戒嗎? Ready to quit?
葡萄酒 Wine	O	O	O					O是Y O 否N
啤酒 Beer	O	O	O					O是Y O 否N
烈酒 Hard Liquor	O	O	O					O是Y O 否N
香菸 Cigarettes	O	O	O					O是Y O 否N
電子菸 E-Cigarettes	O	O	O					O是Y O 否N
其它菸草 Other tobacco	O	O	O					O是Y O 否N
大麻 Marijuana	O	O	O					O是Y O 否N
冰毒/安非他命 Methamphetamines	O	O	O					O是Y O 否N
快克可卡因/古柯鹼 Cocaine/Crack	O	O	O					O是Y O 否N
天使粉 PCP	O	O	O					O是Y O 否N
海洛因 Heroin	O	O	O					O是Y O 否N
搖頭丸 Ecstasy	O	O	O					O是Y O 否N
迷幻藥/貼郵票 LSD	O	O	O					O是Y O 否N
其它 Others (specify):	O	O	O					O是Y O 否N
								O是Y O 否N

14. 您在過去6個月內是否有過以下經歷?（可複選） Have you experienced any of the following in the last 6 months? (Please check all that apply)

全身性 Constitutional

o 疲倦/易累 Fatigue/ tire easily

o 體重減輕: (______) 磅 lbs.

o 難以入睡 Trouble sleeping

o 食慾不振 Poor appetite

o 經常身體疼痛或心情苦惱 Frequent pain or distress

o 發燒 Fevers

o 盜夜汗 Night sweats

眼睛 Eyes

o 視力模糊或複視 Blurring or double vision

o 眼睛痛或發炎 Pain or inflammation in eyes

o 其他眼睛問題 Other eye problems

耳鼻喉 Ears/Nose/Throat

o 口內嚐到酸味 Sour taste in mouth

o 口內有胃逆流物 Stomach contents in mouth

o 鼻竇塞住(充血)或疼痛 Sinus congestion or pain

o 耳內疼痛 Earaches

o 經常性牙齦出血 Frequent gum bleeds

o 喉嚨痛 Sore throat

o 聲音沙啞 Hoarse voice

o 嚴重蛀牙 Severe tooth decay

心臟 Cardiac

o 胸口疼痛 Chest pain

o 心悸(心跳快速) Palpitations (rapid heart rate)

o 夜間醒來呼吸短促 Wake up at night short of breath

呼吸 Respiratory

o 氣喘/哮喘聲 Asthma/wheezing

o 呼吸短促 Shortness of breath

o 咳血 Coughing up blood

o 經常感染 Frequent infection

腎/膀胱 Kidney/Bladder

o 頻尿 Frequent urination

o 小便疼痛 Painful urination

o 尿中帶血 Blood in urine

o 尿失禁 Incontinence/ leakage of urine

血液/淋巴 Blood/lymph

o 貧血 Anemia

o 淋巴結腫大 Large lymph nodes

o 容易流血或淤青 Easy bleeding or bruising

o 血栓/血凝塊 Blood clots

o 接受輸血 Blood transfusions

內分泌 Endocrine

o 感覺太熱或太冷 Feeling too hot or cold

皮膚 Skin

o 起疹子 Rash

o 皮膚上長新東西 New growth on skin

o 潰瘍,瘡,或紅點 Ulcers, sores or red spots

神經科的 Neurological

o 經常性頭痛 Frequent headaches

o 頭暈 Dizziness

o 麻木刺痛感 Numbness or tingling

o 手臂/腿虛弱無力 Weakness of arms /legs

o 記憶力喪失 Memory loss

骨骼肌肉的 Musculoskeletal

o 關節疼痛/骨關節炎 Joint pains/ arthritis

o 無力 Weakness

o 背痛 Back pain

o 多處骨折 Multiple broken bones

心理科的 Psychological

o 工作壓力 Stress at work

o 家庭壓力 Stress at home

o 消沈/憂鬱感 Feeling blue/ depressed

o 焦慮/擔心感 Feeling anxious/ worried

o 不享受生命(活) Not enjoying life

o 性趣缺缺 Loss of interest in sex

o 不愉快的想法 Unpleasant thoughts

o 憂鬱症 Depression

其它 Other

o 性問題 Sexual problems

o 經血量大/異常 Heavy/abnormal menstrual bleeding

O 未勾選的空白圈圈表示沒有那方面的問題. Boxes left blank are negative .