Garfield Health Center

210 North Garfield Avenue, Suite 203, Monterey Park, CA91754

(626) 307-7397

Patient Information

Name (Last, First Middle) 病人姓名	Date of Birth 出生日期	Soc Sec # 病人社安號碼

What was your sex assigned at birth? 你出生時的性別是什麼?

☐ Male 男性 ☐ Female 女性

What is your marital status? 你的婚姻狀況如何？

☐ Single 單身 ☐ Married 已婚 ☐ Divored / Widowed 離婚/喪偶

What is your gender now? 你現在的性別是什麼?

☐ Male 男性 ☐ Female 女性 ☐ Transgender Female-to-Male 轉性別（男）

☐ Transgender Male-to-Female 轉性別（女） ☐ Other 其他 ☐ I prefer not to answer 拒絕回答

Address (Street) 地址(街道)	Apt # (單位號碼)	City, State, Zip 城市, 州, 郵編

Home Phone 家電話	Cell Phone 手機電話	Emergency Contact 緊急聯繫人	Relationship 關係	Phone Number 電話

Employer 工作公司名稱	Occupation 職業	Work Phone 工作公司電話

Race 種族

Asian 亞洲人	Hispanic 西班牙人	Native American Indian印地安人	Unknown 未知
Multi 混血	White 白人	Black of African American 黑人	Other 其他

Language 語言

English 英文	Cantonese 廣東話	Indonesian 印尼話	Thai 泰國話	Other 其他
Spanish 西班牙話	Mandarin 國語	Vietnamese 越南話	Korean 韓文	Japanese 日文

Sexual Orientation 性取向

Straight/ Heterosexual 直或異性戀	Gay/ Lesbian/ Homosexual 男同性戀，女同性戀或同性	Bisexual 雙性戀	Don't Know 不知道	Refuse to Answer 拒絕回答

Vetaran/Military 軍人	Interpreter needed? 需要翻譯員?	Ethnicity 種族
No 不 Yes 是	No 不 Yes 是	Hispanic/Latino Not Hispanic/Latino
Disabled 殘疾	Advance Directives 生前指示	Homeless 無家可歸 / 露宿者
No 不 Yes 是	No 不 Yes 是	No 不 Yes 是

Spouse Information

Spouse's Name (Last, First Middle) 配偶姓名	Spouse's DOB 配偶出生日期	Spouse's Soc Sec # 配偶社安號碼
Spouse's Cell Phone # 配偶手機號碼	Spouse's Work Phone 工作公司電話	
Spouse's Employer 配偶工作公司名稱	Spouse's Occupation 配偶職業	

Income Information

Family Size 家庭人數	Entire Household Monthly Gross Income 家庭每月收入	☐ Refused to Answer 拒絕回答

TODAY'S DATE: ____________________

GARFIELD HEALTH CENTER

GENERAL CONSENT

I hereby request and consent to all diagnostic procedures, including CHDP examinations, X-rays, blood tests, medical treatments, including immunizations and dental treatments deemed advisable by the professional staff of **Garfield Health Center (GHC)**.
I acknowledge that I have read this consent form and understand its contents. I have had an opportunity to discuss it, and any questions I have had, have been answered to by complete satisfaction.
Being the parent or legal guardian of the minor patient, ____________________________, I consent to the above procedures being performed, my signature hereunder, shall be full and sufficient authority. Should the need arise to perform services not set out above; **GHC** may obtain consent by telephone or by letter granting such consent.
I consent to be contacted by mail, e-mail, telephone (including a cell phone number), and text messages regarding any matter related to my account by the practice or any entity to which the hospital assigns my account. I also consent to the use of any updated or additional contact information that I may provide by the practice or any entity to which the practice assigns my account, as well as to the use of technology including auto-dialing, pre-recorded messages, and/or automated text messages in contacting me.

AUTHORIZATION FOR MEDICAL RECORDS RELEASE/REFERRAL AND ASSIGNEMNT OF BENEFITS

I authorize GHC to release my medical/social information to persons or agencies directly concerned with and engaged in carrying out a treatment plan for the patient. Also **GHC** may use and release any part of my medical records necessary to the process of billing third party payers for services rendered on my behalf. I clearly understand that all my information will be kept confidential. I understand that this information will be used to review, investigate, or make payment of a claim, and to review records for quality improvement initiatives, audit compliance, utilization management, and complaint resolution.
I authorize payment directly to **GHC** for all medical benefits otherwise payable to me under terms of my insurance. I understand that I am financially responsible for all co-payments, co-insurance, deductibles, and non-covered services. Overpayments on any **GHC** account may be applied to my patient balance. A photocopy of this authorization shall be considered as effective and as valid as the original.

同意書

我在此要求並同意經由 Garfield Health Center (GHC)的專業人員來取得所有的診斷程序，包括 CHDP 檢查，X 光檢查，驗血，醫療治療，其包括免疫接種和牙科治療。

本人認同其同意書內容並已閱讀此同意書。 我有過機會討論，並且對任何問題都已經得到滿意答复。

身為未成年患者的父母或法定監護人， ____________________________，我本人簽名同意執行上述程序。 如果需要提供以上未列出的服務; GHC 可以通過電話或書面方式獲得同意。

本人同意任何的相關醫療機構，可經通由郵件，電子郵件，電話（包括手機號碼）以及收機簡訊等方式發送關於本人任何的醫療帳號資訊，或關於我的帳號資訊。本人也同意可以使用我提供的任何更新信息，經由自動撥號，預先錄製，自動回覆消息等技術與我聯繫。

醫療記錄授權發布/轉診和轉讓福利

本人授權 GHC 將我的醫療/社安信息發布給執行治療計劃的相關人員或機構。此外，GHC 可以代表本人釋放任何關於我的醫療記錄給第三方付款者進行收費。我清楚地明白關於我的所有信息都將被保密。 我了解這些信息將會用於審查，調查，或支付索賠，和審查質量改進記錄，審計合規，使用管理和投訴解決方案記錄。
本人授權直接支付我的醫療費用給 GHC，或根據我的保險條款支付於本人。我明白我有責任承擔所有醫療自費金額，自廢保險金額，免賠額（自負額），與不覆蓋的服務費用。在 GHC 帳號裡的超額付款將會適用於本人個人餘額。 該授權的複印版本應視與原件一樣有效。

X____ ________________________
Patient or Legal Guardian Signature Date

____
Full Name (print) Date of Birth Relationship (if applicable)

GARFIELD HEALTH CENTER

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT
隱私條例確認通知書

Patient Name 病人姓名**:** ____

(**Last Name** 姓)　　(**First Name** 名字)　　(**Middle** 中間名)

Date of Birth 出生日期**:** _______________

By signing this form, I am acknowledging that:

- I am either the patient or the patient's legal guardian or personal representative;
- I have received a copy of the "Notice of Privacy Practices" for **Garfield Health Center**
- I have received **Garfield Health Center**'s Patient's Bill of Rights in a language I can understand;
- I understand that I may contact **Garfield Health Center** at any time in the future if I have questions about the content of the Notice of Practice and/or the Patient's Bill of Rights.

通過簽署此表格，我認知：

- 我是病人或病人的法定監護人或個人代表;
- 我收到 **Garfield Health Center** 的"隱私條例確認"副本;
- 我收到 **Garfield Health Center** 的權利法案是我能理解的語言;
- 我知道我可以聯絡 **Garfield Health Center** 如果我對隱私條例確認和權利法案的內容有任何疑問.

Patient Name 病人姓名____

Patient Representative 病人代表 ____

Signature 簽名 ____

Date 日期 ____

Past Medical History
過去病史

Date (日期): ________________ Name (姓名): ____________________________________ DOB (出生月日): ____________________

Past Medical History: Have you had any of the following? 過去病史:您有曾經有过任何以下病史嗎?

- ☐ Severe headaches 劇烈頭痛
- ☐ Glaucoma 青光眼
- ☐ Epilepsy (seizures) 癲癇
- ☐ Asthma 氣喘
- ☐ COPD or Emphysema COPD 或肺氣腫
- ☐ Diabetes 糖尿病
- ☐ Ulcer 潰瘍
- ☐ Radiation treatment to head/neck 頭部/頸部的放射治療
- ☐ Tuberculosis (TB) 結核病
- ☐ Close contact with a person who has TB 與有結核病的人密切接觸
- ☐ Are you foreign born? 您在國外出生?
- ☐ Thyroid problems 甲狀腺問題
- ☐ Heart disease – specify______________ 心髒病 – 說明 __________________
- ☐ Rheumatic fever 風濕熱
- ☐ High blood pressure 高血壓
- ☐ Stroke 中風
- ☐ High cholesterol 高膽固醇
- ☐ Blood clots (lungs/legs) 血塊 (肺或腿)
- ☐ Anemia 貧血
- ☐ Cancer 癌症
- ☐ Kidney/bladder problems 腎臟/膀胱問題
- ☐ Losing urine (pee) when you cough/sneeze/laugh 咳嗽/打噴嚏/大笑時會失禁
- ☐ Getting up frequently at night to urinate (pee) 夜間頻繁排尿
- ☐ Liver problems – specify____________ 肝臟問題 – 說明 _________________
- ☐ Rectal bleeding 直腸出血
- ☐ Psychological problems 心理問題
- ☐ Depression 憂鬱症
- ☐ Anxiety/panic disorder 焦慮/恐慌症
- ☐ Suicide attempts 企圖自殺
- ☐ Fractures 骨折
- ☐ Sexual function problems 性功能問題
- ☐ Sexually transmitted disease (STD) or VD 性病 Which one? 哪一個? _______________
- ☐ Prostate problems 前列腺問題
- ☐ Hysterectomy 子宮切除術
- ☐ Irregular periods 不規律的經期
- ☐ HIV infection 人類免疫缺乏病毒感染
- ☐ Pain now or in the last 3 month 現在疼痛或在過去 3 個月內疼痛

Within the last 12 months, have you experienced any uncomfortable touching? Forced sexual contacts?
在過去的 12 個月裡，你有沒有經歷過任何不舒服的接觸？ 強迫性接觸？ ☐ Yes 是 ☐ No 不是

Within the last 12 months, have you been in a relationship in which there were threats, pushing, grabbing, hitting, kicking, breaking things, or other hurting used? ☐ Yes 是 ☐ No 不是
在過去的 12 個月裡，你是否曾經處於一種性的關係有被人威脅，推，抓，打，踢，打破東西或其他傷害？

What is your current method of birth control? ____
您目前的避孕方式是甚麼?

Who was your last doctor? ________________________________ When were you last seen? _________/_______/_______
谁是您最后的主治醫生? 您上次看醫生是什麼時候?

Women: Date of your last Pap smear: ______/_______/________ Date of your last mammogram: ______/_______/________
女性: 你上次子宮頸抹片檢查日期: 上次乳房 X 光檢查日期:
Abnormal Pap Smear 異常子宮頸抹片檢查： ☐ Yes 是 ☐ No 不是

Surgery/Serious Injury/Hospitalization (include year)
手術/嚴重性受傷/住院（包括年份）

______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________

Current Medications: (include any over-the-counter medicines, vitamins, and herbal supplements)
目前使用藥物: (包括任何非處方藥，維生素和草藥補充劑）

______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________

Are you allergic to any drug/medicine? 你有對任何藥物過敏嗎？ ☐ Yes 是 ☐ No 不是

Are you allergic to a food/other substance? 你有對食物或是其他物質過敏嗎? ☐ Yes 是 ☐ No 不是

If yes, list medicine and/or food/substance and describe reaction(s): 如果有，請描述過敏反應:

____

____

Family History: Include parents, sister, brothers, aunts, uncles, grandparents (blood relatives only). **Has any family member had?**
家族歷史: 包括父母，姐姐，兄弟，阿姨，叔叔，祖父母（只有血親）。 有任何親屬有以下？

	Who 誰		**Who 誰**
☐ Migraines 偏頭痛	________	☐ Diabetes 糖尿病	________
☐ Strokes 中風	________	☐ Depression 憂鬱症	________
☐ High blood pressure 高血壓	________	☐ Colon cancer 結腸癌	________
☐ Heart attack/disease 心臟病	________	☐ Substance abuse 藥物濫用	________
☐ Sickle cell anemia 鐮狀細胞性貧血	________	☐ High cholesterol 高膽固醇	________
☐ Breast cancer 乳癌	________	☐ Alcoholism 酗酒	________
☐ Other cancer 其他癌症	________	☐ Fractures 骨折	________
☐ Tuberculosis 肺結核	________		

Is your mother living? ☐ Yes ☐ No How old is she now (or when she died)? ______/______/________
您的母親還在世嗎? 她現年貴更 (或是她什麼時候往生)?

Is your father living? ☐ Yes ☐ No How old is he now (or when he died)? ______/______/________
您的父親還在世嗎? 她現年貴更 (或是她什麼時候往生)?

Social History: 社交歷史

Others living in your home, relationship 與您同居的人, 關係______________________________

What is your level of education? 您的教育程度是什麼?______________________________

What is your present job? 您現任的工作是什麼? ______________________________

Do you have a Durable Power of Attorney for Health Care, Living Will or POLST form? ☐ Yes 是 ☐ No 不是
您是否擁有醫療保健，生前意願或 POLST 表格的持久授權書?

If yes, date completed: 如果有，完成日期: ______/______/________

Description: 敘述: ______________________________

Health Habits 健康習慣

Yes 是	**No** 不是		**Describe**
☐	☐	Current Smoker (type, amount per day, for how long) 抽菸者(種類，每日分量，菸齡)	________
☐	☐	Have you smoked in the past? 以前有抽過菸嗎? (Type, amount per day, age when started, and age quit smoking) (種類，每日分量，開始時年齡, 和戒菸年齡)	________
☐	☐	Alcohol (drinks per week) 酒精 (每週分量)	________
☐	☐	Coffee/tea/cola/energy drinks (cups/cans per day) 咖啡/茶/可樂/能量飲品 (每日分量)	________
☐	☐	Trouble sleeping? (hours you sleep per night) 睡眠問題? (每晚睡眠多少個小時)	________
☐	☐	Weight gain/loss (unintentional) in last 6 months? 過去 6 個月體重增減?	________

☐ ☐ Appetite change? (explain) ______________________
食慾變化?（說明）

☐ ☐ Special diet? (Explain) ______________________
特殊飲食？（說明）

Immunizations: Last **Tetanus** shot (**Td**) ________________ **Flu** Shot __________________ **Pneumonia** Shot_________________
疫苗： 最後破傷風針 流感疫苗針 肺炎疫苗針

Patient Health Questionnaire (PHQ-9): 患者健康問卷:

1. Over the last 2 weeks, how often have you been bothered by any of the following problems?
在過去 2 周內, 你有經常被以下任何問題困擾嗎?

	Not at all 完全不會(0)	Several days 只有幾天(1)	More than half the days 超過一半的時間(2)	Nearly every day 每一天(3)
a. Little interest or pleasure in doing things. 對任何事物都不感興趣				
b. Feeling down, depressed, or hopeless. 感到沮喪，無助或無望。				
c. Troubling falling/ staying asleep, sleeping too much. 無法進入睡眠/保持睡眠，或過度睡眠				
d. Feeling tired or having little energy. 感覺疲倦或沒有能量				
e. Poor appetite or overeating. 食欲不振或是暴飲暴食				
f. Feeling bad about yourself or that you are a failure, or have let yourself or your family down. 對自我感覺不好，覺得自己失敗者，或讓家人失望。				
g. Trouble concentrating on things, such as reading the newspaper or watching TV. 在閱讀報紙或看電視等事情無法集中精神。				
h. Moving or speaking so slowly that other people could have noticed. Or the opposite; being so fidgety or restless that you have been moving around more than usual. 說話及動作緩慢慢到其他人已經註意到了。或者相反; 因為煩躁或焦躁不安，是你比平時更加過動。				
i. Thoughts that you would be better off dead or of hurting yourself in some way. 你認為死亡或是自虐會對你更好				

2. If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?
如果您有在以上調查問卷中選任何項目，那這些問題對您工作，家庭，社交上造成多大的困擾？

☐ Not difficult at all 完全不困擾 ☐ Somewhat difficult 有一點困擾 ☐ Very difficult 很困擾 ☐ Extremely difficult 非常困擾

Total Score ____________

Date / 日期: ______________________

Name / 名字: ______________________ **Date of Birth / 出生日期:** ______________

TB Risk Assessment 肺結核的風險評估表		
Risk Factors 風險因素	**Yes** 是	**No** 無
Recent close or prolonged contact with someone with infectious TB disease 您近期有和傳染性肺結核病人密切或長期接觸嗎?		
Foreign-born person from or recent travelor to high-prevalence area 出生在美國以外或近期去過有高度流感肺結核的地區旅行。		
Chest cardiographs with fibrotic changes suggesting inactive or past TB 您在做血液透析嗎?		
HIV infection 您是爱滋病感带原者吗?		
Organ transplant recipient 您是器官移殖接受者嗎?		
Immunosupression secondary to use of prednisone (equivalent of ≥15 mg/day for ≥1 month) or other Immunosuppressive medication such as TNF -α antagonists 由于使用強的松其它免疫抑制劑(如組織壞死因子)所造成的免疫抑制狀態。		
Injection drug user 您是注射毒品者嗎?		
Resident or employee of high-rsik congregate setting (e.g., prison, TLC facility, hospital, homeless shelter) 居住或工作在高危險場所(如監獄, 老人院, 醫院, 無家可歸者收容所, 等等)。		
Medical condition associated with risk of progressing to TB disease if infected (e.g., diabetes mellitus, silicosis, cancer of head or neck disease, intestinal bypass or gastrectomy, chronic malabsorption syndrome, low body weight [10% or more below ideal for given population) 易導致肺結核的疾病: 如糖尿病, 矽肺, 頭部或頸部的癌症疾病, 淋巴瘤, 敗血病, 晚期腎病, 小腸轉流或胃切除手術, 慢性吸收不良綜合症, 低體重(低于10%或更多)。		
Sign and symptoms of TB 您有肺結核的症狀嗎?		
Hepatitis B Risk Assessment 乙型肝炎的風險評估表		
Were you born outside of America? If yes, Where? 你出生在美國以外的地方嗎?如果是的話,在哪裡?		
Are you pregnant? 你懷孕了嗎?		
Are you on Hemodialysis? 你血液透析嗎?		
Are your family member(s) or sex parther HBV infected? 在您的家庭成員或性伴侶是乙型肝炎帶菌者嗎?		
Are you a man who has sex with men (MSM)? 你是男同性戀者嗎?		
Are you HIV positive? 你是性病帶菌者嗎?		
Are you injection drug user? 你有没有使用毒品或注射毒品?		
Are you working in a health care facility? 你在一個醫療機構工作嗎?		
Are you the source of blood or body fluid exposed? 你是血液源或體液接觸者嗎?		