Pre-Visit Health Questionnaire

年度预防性医疗访问 - 诊前健康问卷
Annual Preventive Care Visit / Pre-Visit Health Questionnaire

【患者信息 | **Patient Information**】
姓名 (Full Name): _____ 出生日期 (DOB): _____
电话 (Phone): _____ 电子邮箱 (Email): _____
首选语言 (Preferred Language): □ English □ 中文 (Chinese) □ Other: _____

【第一部分：就诊原因 | Reason for Visit】
□ 年度体检 (Annual Physical / Preventive Visit)
□ 复诊 (Follow-up) 原因 (Reason): _____
□ 新症状/问题 (New Concern): _____

本次就诊您最希望解决的 1-2 个问题是什么？
What are your top 1-2 goals for today's visit?

1.
2.

【第二部分：病史与家族史 | Medical & Family History】

1. 您是否被诊断过以下疾病？(Check any that apply)
   □ 高血压 (High Blood Pressure) □ 糖尿病 (Diabetes) □ 高胆固醇 (High Cholesterol)
   □ 心脏病 (Heart Disease) □ 癌症 (Cancer) □ 抑郁症/焦虑症 (Depression/Anxiety)
   □ 其他 (Other): _____
2. 家族病史 (直系亲属：父母、兄弟姐妹、子女) | Family History (First-degree relatives)
   □ 心脏病 (55 岁前男/65 岁前女) | Heart Disease (Male<55 / Female<65)
   □ 糖尿病 | Diabetes
   □ 癌症 (类型 | Type): _____ 亲属关系 | Relation: _____
   □ 中风 | Stroke
   □ 其他 | Other: _____

【第三部分：用药与过敏 | Medications & Allergies】

1. 请列出当前所有用药 (处方药、非处方药、保健品)
   List all current medications (Prescriptions, OTC, Supplements)
   名称 | Name: _____ 剂量 | Dosage: _____ 频率 | Frequency: _____
   名称 | Name: _____ 剂量 | Dosage: _____ 频率 | Frequency: _____
2. 过敏史 | Allergies
   □ 无 (None)
   □ 药物 (Medications): _____ 反应 (Reaction): _____
   □ 食物/其他 (Food/Other): _____ 反应 (Reaction): _____

【第四部分：生活方式与风险因素 | Lifestyle & Risk Factors】
(用于评估筛查资格，如肺癌、心血管风险 | For screening eligibility)

1. 吸烟史 | Smoking History
   □ 从不 (Never)
   □ 已戒烟 (Former) 戒烟年份 | Year Quit: _____
   □ 目前吸烟 (Current) 每天 ___ 支 | cigarettes/day 吸烟 ___ 年 | years
   (注：≥20 包年吸烟史可能符合肺癌筛查资格 | Note: ≥20 pack-years may qualify for lung screening)
2. 饮酒 | Alcohol
   □ 无 (None) □ 偶尔 (Occasional) □ 规律 (Regular): ___ 杯/周 | drinks/week
3. 运动 | Exercise
   每周 ___ 天 | days/week 每次 ___ 分钟 | minutes/session
4. 睡眠与压力 | Sleep & Stress
   平均睡眠 | Avg Sleep: ___ 小时/晚 | hours/night
   压力水平 | Stress Level (1-10): ___

【第五部分：预防筛查记录 | Preventive Screening History】
(根据 USPSTF 指南 | Based on USPSTF Guidelines)

1. 结肠癌筛查 (45 岁起) | Colon Cancer (Start age 45)
   □ 未做过 (Never) □ 粪便检测 (FIT) 日期 | Date: /□ 结肠镜 (Colonoscopy) 日期 | Date: /

2. 癌症筛查 (女性适用 | For Women)
   □ 乳腺癌 (乳腺 X 光) | Breast Cancer (Mammogram): /
   □ 宫颈癌 (Pap/HPV) | Cervical Cancer (Pap/HPV): /
3. 前列腺筛查 (男性适用 | For Men)
   □ 已讨论 PSA 检测 (PSA discussed) □ 未讨论 (Not discussed)
4. 疫苗接种 | Vaccinations
   □ 流感 (Flu) □ 新冠 (COVID) □ 破伤风 (Tetanus) □ 带状疱疹 (Shingles) □ 肺炎 (Pneumonia)

【第六部分：系统回顾 | Review of Systems】
过去 3 个月是否有以下症状？(Any symptoms in past 3 months?)
□ 体重变化 (Weight change) □ 胸痛/气短 (Chest pain/Shortness of breath)
□ 腹痛/消化问题 (Abdominal/Digestive) □ 头痛/头晕 (Headache/Dizziness)
□ 情绪变化 (Mood changes) □ 其他 (Other): _____

妇科FEMALES: DO YOU DO BREAST SELF-EXAMS?

DATE OF YOUR LAST ANNUAL EXAM/PAP?

HAVE YOU HAD ANY ABNORMAL PAPS?

AGE OF FIRST MENSES? ARE YOU SEXUALLY ACTIVE?

PRE- MENOPAUSAL FEMALES:

- Irregular Cycle
- No Cycle
- Bleeding Between Cycles
- Abnormal Bleeding
- Painful Menses
- Clotting
- Heavy Or Excessive Flow
- Discharge
- PMS
- Birth Control

- Difficulty Conceiving
- Perimenopausal

WHAT IS THE DURATION OF YOUR MENSES?

WHAT IS THE LENGTH OF YOUR CYCLE?

IF YOU ANSWERED YES TO BIRTH CONTROL, WHICH TYPE ARE YOU ON?

MENOPAUSAL FEMALES:

WHAT AGE WAS YOUR LAST MENSES?

DO YOU HAVE ANY MENOPAUSAL SYMPTOMS?

ANY VAGINAL BLEEDING SINCE MENOPAUSE?

IS THERE ANYTHING ELSE YOU WOULD LIKE TO ADD OR COMMENT ON?

【声明与签名 | Consent & Signature】
我证明以上信息属实。我同意将此信息用于医疗目的。
I certify this information is accurate. I consent to use for medical purposes.

签名 | Signature: _____ 日期 | Date: ____
(电子提交视为签名 | Electronic submission constitutes signature)