OAHU OBGYN

Obstetrics and Gynecology

Kukui Plaza: 50. S. Beretania St. Suite C-211C Honolulu, HI 96813 (F) 808-532-2027
Mehana Kapolei: 1020 Kakala St #903 Kapolei, HI 96707 (F) 808-674-8936

Phone: (808) 532-2020 **Fax**: 1 (808) 495-4236 **After Hours**: (808)524-2575

Gynecology Initial Intake Form 婦科調查表

Name(姓名): _____ Date(日期): _____/_____/_____

Social Security Number: _____ Date of Birth: _____/_____/_____ Age: _____
工卡号码 出生日期 年齡

Address:_____
地址 Street 街名 Apt# City 城市 State 州 Zip Code 郵區號碼

Home #:_____ Cell #:_____ Work #:_____
家庭電話 手機電話 工作電話

Preferred Number to a Leave Message: _____ Email: _____
首選留言的电话号码 電郵

Marital Status (circle one): Married Single Divorced Separated Widowed
婚姻狀況（请圈一个）: 已婚 独身 離婚 分居 寡婦

Employer (雇主): _____ Occupation (職業): _____

Employer's address: _____ _____
雇主地址 Street 街名 City 城市 State 州 Zip Code 郵區號碼

In Case of an Emergency, Notify: _____ Relationship:_____
在緊急的时候，联系人： 關係

Phone number (day): _____ Phone number (night): _____
电话（早上） 电话（晚上）

Primary Care Physician:_____
家庭醫生

Referred by (介紹人): _____Preferred Language(s) (首選語言): _____

ALL PROFESSIONAL SERVICES ARE CHARGED TO THE PATIENT. THE PATIENT IS RESPONSIBLE FOR ALL FEES REGARDLESS OF INSURANCE COVERAGE.
所有診金及费用將由本人负责。

PLEASE READ AND SIGN

I hereby authorize Lynette W. Tsai, MD, Inc. to furnish information to insurance carriers concerning my illness and treatments. I also authorize Dr. Tsai to furnish necessary information regarding my health to other physicians participating in my care if they request it. If I do not desire to release such information, I will inform Dr. Tsai in writing. I hereby assign to the physician all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by my insurance. I also understand there is a $25-$50 fee for release of medical records. Unless extenuating circumstances apply, I agree to cancel or reschedule my appointment within 24 hours. I understand that I will be responsible for a $50.00 fee for any missed appointment. All fees are subject to change.

我在此授權蔡醫生诊所向保險公司提供有關我的疾病和治療的信息。我還授權蔡醫生向參與我護理的其他醫生提供有關我健康的必要信息。如果我不想发送這些信息，我會以書面形式通知蔡醫生。我会付醫生向我或我的家屬提供醫療服務的所有款項。我明白我会對我的保險未涵蓋的任何金額負責。我知道病歷的费用为 25 美元至 50 美元。除非特殊原因，否则我同意在 24 小时内取消或重新安排我的预约。我知道对于任何错过的预约，我将负责 50 美元的费用。所有费用可能会有所变化。

Signature (签名):_____ Date(日期): _____/_____/_____

Name: _____ Date: _____/_____/_____
姓名 日期

Reason for your visit: **有什么問題要见醫生啊?**

_____

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**		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 **痉癇症(發痉癲)**	
GI reflux disease **腸胃逆流疾病**		Liver problem **肝病**		Asthma **哮喘**	
Fibroids **纖維瘤**		Kidney infections **腎感染**		Lung disease **肺病**	
Endometriosis **子宮內膜異位**		Kidney stones **腎結石**		Tuberculosis **肺結核**	
Osteopenia **骨質稀少**		Arthritis **關節炎**		Thyroid disease **甲狀腺病**	
Osteoporosis **骨質疏鬆症**		Joint pain **關節痛**		Clotting problem **凝結問題**	
Cancer (Type) **癌症(類型)**		Fracture **骨折**			
Add others/Explains: **其他/解釋:**					

Current Medications: 现在食的藥物:

Drug Names **藥名**	Dosage **劑量**	Start Date **開始**

Allergies: 過敏:

Allergic to: 過敏	Allergic Reaction: **反應**

Family History 家庭歷史

Major Illnesses 主要疾病	**Yes,** who? **有，是谁**		**Yes,** who? **有，是谁**		**Yes,** who? **有，是谁**
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**	
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Osteoporosis **骨質疏鬆症**		Joint pain **關節痛**		Clotting problem **凝結問題**	
Cancer (Type/Relation) **癌症(類型/關係)**		Fracture **骨折**			

Hospital & Surgical History 外科手術歷史

Year 年份	Illness/ Surgery 外科手術	Surgeon 外科醫生	Hospital 医院

Pregnancy History 懷孕歷史

	Number 多少		Number 多少
Total # of pregnancies 受孕次數		Living children 生存孩子數目	
Miscarriages 流產		Vaginal deliveries 自然分娩	
Abortions 墮胎		Cesarean sections 剖腹分娩	

Year 年	Duration of Pregnancy 是否足月码?	Vaginal delivery? 是否正常分娩?	Sex 男/ 女	Hours in Labor 待產時間	Epidural Y or N 麻醉針	Weight 体重	Hospital 醫院	Complications 並發症

Please describe any special pregnancy problems: 請敘述任何懷孕期問題:

_____

_____

Menstrual History

Age at first period: 月經初潮? _____ Number of days of flow: 持續流多少天_____ days 天

Are your periods regular (every 28-30 days)? 週期是（28-30）天? ____ yes 是 ____ no 否

If not, how often? 如果答案是否，有几多天 _____ days 天

Number of pads 用多少卫生巾 ___ or tampons 或棉体條 _____ used on heaviest day 在月經第二天?

Menstrual flow 月經 (please check one): □ light 少量 □ moderate 中量 □ heavy 大量

Are your periods painful (cramps) 有没有经痛 ? ___ yes 是___ no 否

Do you use painkillers to treat your cramps? 如有经痛， 你会吃用止痛片吗？ ___yes 有 ____no 否

When was the first day of your last menstrual period? 最後一次月經期? _____/_____/_____

If menopausal, how old were you when it occurred? 你是否已停经_____

Are you taking hormones? 你有没有吃用激素 ___ yes 有 ___ no 否

If so, what type and dosage? 吃用何钟激素 _____

Gynecological History 婦科歷史

Have you ever been treated for: **曾經有過的性病:** □ Herpes **胞疹** □ 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** Date **日期** ___/___/___
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** Date **日期** ___/___/___
What Abnormality? **什麼不正常?** _____
If over age 35, have you had a mammogram? **如果你超過 35 歲, 你曾否做过乳房 X 光檢查?**
□ No **沒有** □ Yes **有** Date **日期** ___/___/___ **地方** _____
If over age 50, have you had a bone density scan done? **如果你超過 50 歲, 你曾否做过骨質 X 光檢查?**
□ No **沒有** □ Yes **有** Date **日期** ___/___/___**地方** _____

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? **你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? **你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**

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**
If yes, current birth control: **如有, 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?
你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** □ Unknown **不知道**

Social History 社會歷史

Personal Profile 個人簡介

Birth Place:_____ Ethnicity:_____ Religion: _____
出生地方 種族

School Completed: 學歷程度: □ High School 高中 □ College 大學 □ Graduate School 研究院 □ Other 其他

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

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	
Street Drugs 吸毒	□ Yes	□ No	If so, what did you use? _____ 如果有用的，你用过什么？		

Do you use seatbelts? 你用不用安全帶? □ Yes 用 □ No 不用
Do you use sunscreen? 你用不用防曬油? □ Yes 用 □ No 不用
Do you own guns in your home? 你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你?
□ 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, 包括你的伴侶,強迫與你發生性行為?
□ Yes	□ No	Are you ever afraid of your partner? 你怕你的伴侶嗎?

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

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.

PRIVACY PRACTICES ACKNOWLEDGEMENT

ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy Practices and I been provided an opportunity to review it.

I acknowledge that by adding or switching to QUEST insurance may result in termination of care with Oahu OBGYN. I understand I will be held responsible for any outstanding balance accrued and establish OBGYN care with a new provider.

Print Name_____ **Birthdate**____/_____/_____

Signature_____ **Date**____/_____/_____

OAHU OB/GYN

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

The Health Insurance Accountability and Portability Act of 1996, HIPPA, requires that our office has your consent prior to our healthcare professional discussing your personal health with your family members or significant others.

*Can our Providers discuss your healthcare with any of your family members? YES / NO (please ***circle***)

*Name	Relationship	Telephone Number
_____	_____	_____
_____	_____	_____
_____	_____	_____

*What kind of health information do you authorize Oahu OB/GYN to disclose to the designated person(s)?

____ All – at my Provider's discretion _____ Tests ordered _____Test Results
____ Date of Treatment _____ Diagnosis _____ Treatment Options
____ Treatment Plan _____Medical History ___Other_____

This authorization will be in effect until such time you request its revision. You have the right to revoke this authorization in writing except to the extent the practice has acted in reliance upon this authorization.
You do not have to complete this authorization in order to receive treatment from Oahu OB/GYN.
Personal Health Information covered by this authorization will be disclosed only for the purpose of keeping your designated family members knowledgeable about your healthcare condition.

*_____ * ____/_____/_____
Signature Date

*_____ * _____/_____/_____
Print Name BIRTHDATE

* E-mail: _____@_____._____

OAHU OBGYN

(P) 808-532-2020 | **Elation EMR Fax: 1-808-495-4236**
LYNETTE TSAI, M.D., KATHY GADAINGAN, APRN, ERICA CADIZ-SALES, APRN.

COVID-19 SCREENING NOTICE

The safety of our employees is our overriding priority. As the coronavirus (COVID-19) pandemic continues, we are monitoring the situation closely and following the guidance from the Centers for Disease Control and Prevention and local health authorities. In order to prevent the potential risk of exposure to our staff and patients we ask that you please respond to each of the following questions truthfully and to the best of your ability

BY ENTERING THIS WORKSITE, YOU ARE AFFIRMING AND REPRESENTING THAT:

1. In the past 4 weeks you have NOT tested positive for COVID-19, or you are NOT presumptively positive for COVID-19 based on your health care provider's assessment or your symptoms.

2. You have NOT been tested for COVID-19 in the last 2 weeks or waiting to receive test results.

3. You are NOT currently experiencing, or have NOT experienced any of the following symptoms in the last 14 days:

☐ Cough
☐ Shortness of breath or difficulty breathing
☐ Fever of 100.4° F or higher
☐ Chills
☐ Muscle pain
☐ Sore throat
☐ New loss of taste or smell
☐ Nausea, diarrhea, vomiting

4 You have NOT, in the past 14 days, been in close contact to anyone who experienced any of the above symptoms or has experienced any of the above symptoms since your contact.

5 You have NOT, in the past 14 days, been in close contact to anyone who has tested positive for COVID-19.

6 You are NOT subject to any Hawaii state or county inter-island travel quarantine order.

_____

Name Signature Date