Arthur Po-Fei Chou, M.D.

120 W Hellman Ave # 204, Monterey Park, CA 91754
Tel: (626) 768-7373 • Fax (626) 478-3373

For Staff Use Only	
Height	Influenza Vaccine
Weight	Pneumonia Vaccine
Vitals	

Patient Information / 患者资料

(Please Print / 请用正楷书写中文)

Name / 姓名: _____
First Name / 名字 Middle Name / 中間名 Last Name / 姓氏

Date of Birth / 出生日期: _____/_____/_____ Age / 年龄: _____
MM / 月份 DD / 日期 YYYY / 年份

Gender / 性别:

☐ Male / 男 ☐ Female / 女 (Pregnant? / 懷孕?: Yes / No / 是 / 否)

☐ Other / 其他 ☐ Decline to Specify / 拒絕說明

Social Security Number / 社會安全號碼: _____

Address / 住址: _____

City / 城市: _____

State / 州: _____ Zip Code / 郵編號碼: _____

Home Phone # / 座機號碼: _____ - _____ - _____ , _____ - _____ - _____

Cell Phone # / 手機號碼: _____ - _____ - _____ , _____ - _____ - _____

Email Address / 電子郵件地址: _____

Occupation / 職業: _____

Employer Name / 公司名稱: _____

Work Phone # / 公司電話: _____ - _____ - _____, ext. _____

Employer Address / 公司地址: _____

City / 城市: _____

State / 州: _____ Zip Code / 郵編號碼: _____

Emergency Contact / 緊急聯絡人: _____

Relationship / 關係 (他/她是你的誰?): _____

Contact # / 聯絡號碼: _____ - _____ - _____ , _____ - _____ - _____

Do you authorize us to discuss your medical condition with the person listed above?
您是否授權本診所與上述人員討論您的醫療狀況? ☐ Yes / 是 ☐ No / 否

Referring Doctor / 介紹你來這裡看診的醫生的名字: _____

Clinic Phone # / 診所電話: _____ - _____ - _____ , _____ - _____ - _____

Primary Care Doctor / 家庭醫生的名字: _____

Clinic Phone # / 診所電話: _____ - _____ - _____ , _____ - _____ - _____

Reason for Today's Visit / 今天來見醫生的主要原因:

_____

_____

_____

_____

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Race / 種族:
☐ American Indian or Alaska Native / 美洲印第安人或阿拉斯加原住民
☐ Asian / 亞洲
☐ Black or African American / 黑人或非洲裔美國人
☐ Native Hawaiian or Other Pacific Islander / 夏威夷原住民或其他太平洋島民
☐ White / 白人
☐ Other Race (Please Specify) / 其他種族: (請註明): _____
☐ Decline to Specify / 拒絕說明

Ethnicity / 族群:
☐ Hispanic or Latino / 西班牙裔或拉丁裔
☐ Not Hispanic or Latino / 非西班牙裔或拉丁裔 ☐ Decline to Specify / 拒絕說明

Preferred Language (Multiple Choice) / 使用語言 (可多選):
☐ Cantonese / 廣東話 ☐ English / 英語
☐ Mandarin / 國語、普通话 ☐ Spanish / 西班牙語
☐ Other (Please Specify) / 其它 (請註明): _____

Handedness / 習慣使用的手:
☐ Left-Handed / 左手 ☐ Right-Handed / 右手

Medical History (Please Mark) / 既往病史 (請勾選):
☐ None / 沒有
☐ Asthma / 哮喘
☐ Bleeding Tendency / 出血傾向、凝血病
☐ Cancer (Please Specify) / 癌症 (請註明): _____
☐ Cranial Aneurysm / 腦動脈瘤
☐ Diabetes / 糖尿病
☐ Gastritis / 胃炎
☐ Heart Disease / 心髒病
☐ Hepatitis / Liver Disease / 肝炎、膽結石
☐ Hereditary Defects / 遺傳性缺陷
☐ HIV / AIDS / 艾滋病
☐ Hypertension / High Blood Pressure / 高血壓
☐ Osteoarthritis / 骨關節炎
☐ Renal / Kidney Disease / 腎病
↳☐ Are you on dialysis? / 您是否做過洗腎、透析? ☐ Yes / 是 ☐ No / 否
☐ Rheumatoid Disease/ Gout / 風濕、類風濕、痛風
☐ Seizures / 癲癇
☐ Stroke / 中風
☐ Tuberculosis (TB) / 結核病
☐ Other (Please Specify) / 其它 (請註明): _____

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Surgical History / 手術歷史:
☐ Yes / 是
☐ None / 沒有
If Yes, please list any surgeries, hospitalizations, or traumatic injuries you have had, including the year and name of the hospital(s).
如果選擇是，請列出您接受過的任何手術、住院、外傷，包括醫院的年份和名稱。

_____
_____
_____
_____

Are you taking medicine? / 你在吃藥嗎? :
☐ Yes / 有
☐ No / 沒有
If Yes, please list all current medications (prescriptions, over-the-counter, herbal, etc.)
如果選擇是，請列出所有正在使用的藥物（處方藥、非處方藥、草藥等）

Pharmacy / 药房的名字: _____; **Phone # / 電話**: _____
Address / 地址: _____

Medication Name and Dose 藥品名稱和劑量	Frequency 頻率 (怎麼吃)	Uses 用來治療什麼	Prescribing Doctor 開藥醫生是誰

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Allergies / 過敏歷史:
☐ None / 沒有
☐ Anesthetic / 麻藥、麻醉劑: _____
☐ Codeine / 可卡因、可待因: _____
☐ Penicillin / 青霉素: _____
☐ Sulfa / 磺胺類藥物: _____
☐ Latex / 乳膠 ☐ Rubber / 橡胶 ☐ Tape / 膠帶
☐ Food Allergies / 食物過敏: _____
☐ Other Drug Allergies / 其它過敏藥物: _____

Family History (Please Mark) / 家族病史 (請勾選):
☐ None / 沒有
☐ Family History Unknown / 家族病史未知、不清楚
☐ Asthma / 哮喘
☐ Bleeding Tendency / 出血傾向
☐ Cancer (Please Specify) / 癌症 (請註明): _____
☐ Cranial Aneurysm / 腦動脈瘤
☐ Diabetes / 糖尿病
☐ Gastritis / 胃炎
☐ Heart Disease / 心髒病
☐ Hepatitis / Liver Disease / 肝炎、膽結石
☐ Hereditary Defects / 遺傳性缺陷
☐ HIV / AIDS / 艾滋病
☐ Hypertension / High Blood Pressure / 高血壓
☐ Osteoarthritis / 骨關節炎
☐ Renal / Kidney Disease / 腎病
☐ Rheumatoid Disease/ Gout / 風濕、類風濕、痛風
☐ Seizures / 癲癇
☐ Stroke / 中風
☐ Tuberculosis Infection / 結核病
☐ Other (Please Specify) / 其它 (請註明): _____

Height / 身高: ____ Feet / 英尺 ____ Inches / 英寸 or / 或 ____ Centimeters / 厘米

Weight / 體重: ____ Pounds / 磅 or / 或 ____ Kilograms / 公斤

Have you had any of the following vaccines this year? / 您今年接種過以下疫苗嗎? :
Flu Shot / 流感疫苗、感冒針: ☐ Yes / 是 ☐ None / 沒有
Pneumonia Vaccine / 肺炎疫苗、肺炎針: ☐ Yes / 是 ☐ None / 沒有

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Social History / 社會史

Ability to Work / 工作能力
- ☐ Not limited / 不受限制
- ☐ Moderately limited / 中度受限
- ☐ Severely limited / 嚴重受限

Are you retired? / 你退休了嗎?
- ☐ Yes / 是
- ☐ No / 沒有

Disability / 殘疾狀況
- ☐ Not disabled / 沒有殘疾
- ☐ Disabled / 已經殘疾
- ☐ Applying for disability / 正在申請殘疾

Marital Status / 婚姻狀況
- ☐ Single / 單身
- ☐ Married / 已婚
- ☐ Divorced / 離婚
- ☐ Widowed / 喪偶

Alcohol Use / 饮酒状况
- ☐ Never / 從不
- ☐ 1-5 weekly / 每週 1-5 次
- ☐ > 2 daily / > 2 天
- ☐ Quit / 已戒酒
  - ↳When did you quit? / 你是什麼時候戒酒的? _____

Tobacco Use / 抽煙狀況
- ☐ Never / 從不
- ☐ Occasional / 偶爾
  - ↳How many packs a day? / 一天抽幾包煙? _____
- ☐ Quit / 已戒菸
  - ↳When did you quit? / 你是什麼時候戒菸的? _____

Other Substances / 非醫療用藥（例如：大麻）
- ☐ Type/Name of the drug / 該物質的類型/名稱: _____
- ☐ Never / 從不
- ☐ Occasional / 偶爾
- ☐ Frequent / 經常

*The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at https://openpaymentsdata.cms.gov.

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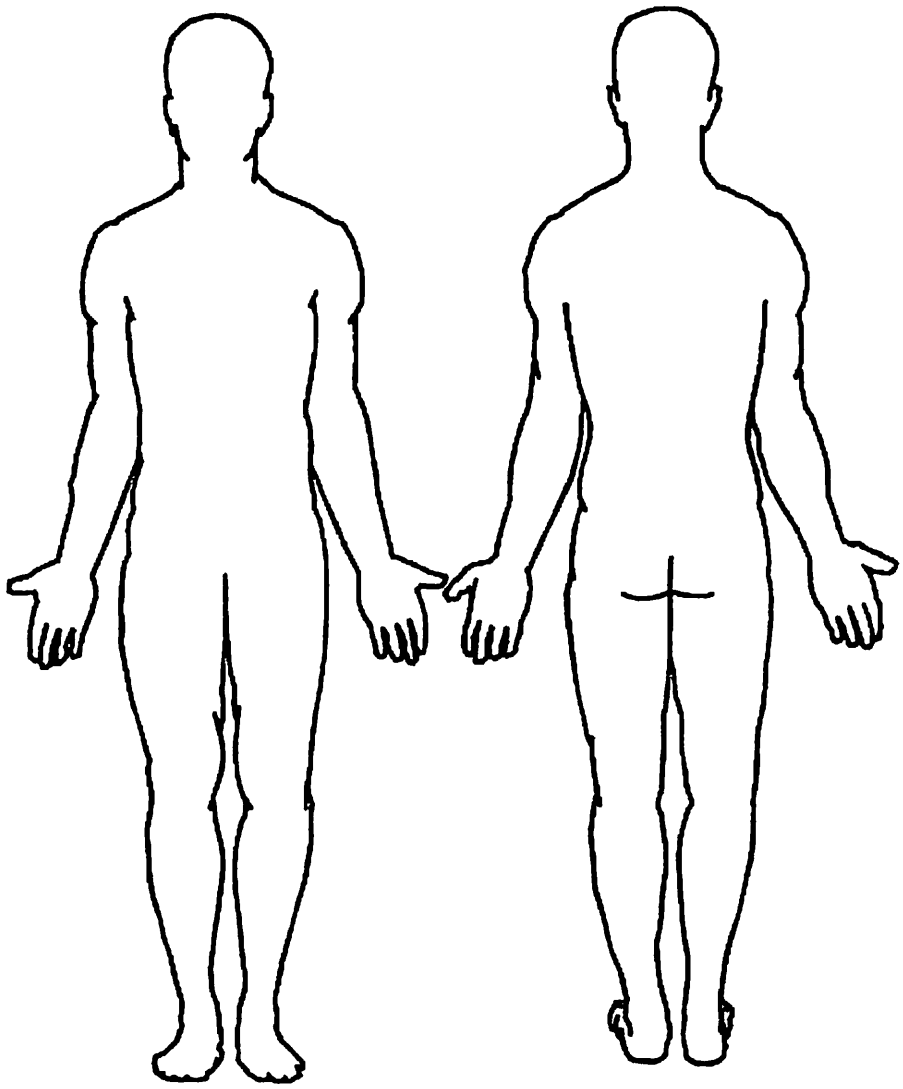
Please draw where your pain is:
請畫出你感到疼痛的位置

Front / 正面 Back / 背面



When did your pain start? / 您的疼痛是從什麼時候開始的? _____

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How often do you have pain? / 疼痛的頻率? _____

Your pain is / 您的疼痛是:
☐ Sharp / 尖銳的痛
☐ Shooting / 射擊樣痛
☐ Tingling / 針扎樣痛
☐ Numb / 麻木
☐ Heavy / 沉重感
☐ Other (Please Specify) / 其它 (請註明): _____

How bad is your pain on a scale of 0 to 10? / 您的疼痛有多嚴重，以0到10為限制?
0 (No Pain / 不痛) 1 2 3 4 5 6 7 8 9 10 (Worst / 非常痛)

Has your pain gotten better over time? / 隨著時間的推移，您的疼痛有沒有好轉?
☐ Better / 減轻、好轉 ☐ Same / 沒有變化 ☐ Worse / 加重、惡化

Do you have pain when you first wake up? / 您在早晨剛醒來時是否會感到疼痛?
☐ Yes / 是 ☐ None / 沒有

Does your pain change with these positions?
當你做這些姿勢時，您的疼痛有沒有變化?

Laying Down / 平躺:
↳ ☐ Better / 減轻、好轉 ☐ Same / 沒有變化 ☐ Worse / 加重、惡化
Sitting / 坐著:
↳ ☐ Better / 減轻、好轉 ☐ Same / 沒有變化 ☐ Worse / 加重、惡化
Standing / 站立:
↳ ☐ Better / 減轻、好轉 ☐ Same / 沒有變化 ☐ Worse / 加重、惡化
Walking / 走路:
↳ ☐ Better / 減轻、好轉 ☐ Same / 沒有變化 ☐ Worse / 加重、惡化
When bending forward and/or backward / 向前和/或向後彎腰時:
↳ ☐ Better / 減轻、好轉 ☐ Same / 沒有變化 ☐ Worse / 加重、惡化

How does your pain affect your daily life?
您的疼痛對您的日常生活造成的影響是?

_____
_____
_____
_____
_____

What types of studies and treatments have you had?

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您做過什麼檢查或測試?
☐ None / 沒有
☐ X-Ray / X 射線 (X 光)
☐ CAT Scan / 電腦斷層掃描 (CT檢查)
☐ MRI / MRA / 核磁共振成像 / 核磁共振血管成像
☐ EMG / NCV / 肌電圖及神經傳導檢查
☐ Injections / 打止痛針/類固醇針
☐ Physical Therapy / 物理治療 (理療、復建)
☐ Other (Please Specify) / 其它 (請註明): _____

If you have tried physical therapy, was your last session within the last 6 months?
如果您嘗試過物理治療，您是在過去 6 個月內做的物理治嗎?
☐ Yes / 是
☐ No / 不是
↳**Did physical therapy provide significant relief?**
物理治療對您有明顯或比較明顯的幫助嗎?
☐ Yes / 有
☐ No / 沒有

Have you tried injections for the pain?
您之前有嘗試過通過打止痛針/類固醇針的方法止痛嗎?
☐ Yes / 有
☐ No / 沒有
↳ **Any significant relief?**
這個方法對您有明顯或比較明顯的幫助嗎?
☐ Yes / 有
☐ No / 沒有

Are you interested in considering surgery?
您是否有想要做手術的意願?
☐ Yes / 是
☐ No / 沒有

PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: **Agreement to Arbitrate:** It is understood that any dispute as to medical malpractice, that is as to whether any medical services tendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: **All Claims Must be Arbitrated:** It is the intention of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or service provided by the physician including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician's partners, associates, association, corporation or partnership, and the employees, agents and estates of any of them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action in any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim.

Article 3: **Procedures and Applicable Law:** A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, not supplant, any other applicable statutory or common law.

Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to, Code of Civil Procedure Sections 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrators a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure section 1283.05, however, depositions may be taken without prior approval of the neutral arbitrator.

Article 4: **General Provisions:** All Claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Article 5: **Revocation:** This agreement may be revoked by written notice delivered to the physician within 30 days of signature. It is the intent of this agreement to apply to all medical services rendered any time for any condition.

Article 6: **Retroactive Effect:** If patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment) patient should initial below:

Effective as of the date of first medical services

_____
Patient's or Patient Representative's Initials

If any provision of this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

By: _____ _____
Physician's or Authorized Representative's Signature (Date)

Arthur P. Chou, M.D.
Print or Stamp Name of Physician, Medical Group or Association Name

By _____ _____
Patient's or Patient Representative's Signature (Date)

By _____
Print Patient's Name

_____
(If Representative, Print Name and Relationship to Patient)

A signed copy of this document is to be given to the Patient. Original is to be filed in Patient's medical records.