# Yuen Podiatry PC

**Dr. Shing Cheung Yuen DPM 袁誠璋醫生**

**Dr. Qian Xu DPM 徐芊醫生**

*Foot and Ankle Specialists* 腳科專科醫生

1810 College Point Blvd., Flushing, NY, 11356 85-10 Queens Blvd., Elmhurst, NY, 11373 2044 86th Street, Brooklyn, NY, 11214

Tel: (646) 520- 7027 Fax: (929) 242-4312

姓名 名 中間名 姓 出生日期 年齡

**Name:** _____ **Date of Birth:** _____ **Age:** _____

**First** **Middle** **Last**

地址 城市 州 郵區號碼

**Mailing Address:** _____ **City** _____ **State** _____ **Zip** _____

手機號碼 家庭電話號碼 工卡號碼 性別 男 女

**Cell #:** _____ **Home phone:** _____ **Soc. Security #:** _____ **Sex:** **( ) Male** **( ) Female**

請勾選 單身 已婚 離異 喪偶 分居

**Check Appropriate Box** ☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Widowed** ☐ **Separated**

職業 緊急聯絡人 與病人的關係

**Occupation:** _____ **Emergency contact & number:** _____ **Relationship to Patient:** _____

今日看診的原因

**What is your chief complaint?** _____

這是你第一次來醫治這個問題嗎？ 是 否 如果不是第一次， 過往的治療方法是什麼？

**Is this the first time you are being treated for this problem?** ☐ ☐ **If no, what were the treatments:**

**Yes** **No**

你目前有在家庭醫生的照顧底下嗎？ 有 沒有

**Are you currently under a physician's care?** ☐ ☐

**Yes** **No**

如有， 是因為什麼原因呢？ 你上一次什麼時候看家庭醫生的？

**If yes, for what?** _____ **, and when was the last time you saw your primary care doctor ?**

你有經歷以下病症嗎**?** 足部冰冷，麻痹，刺痛，或者其他不尋常感覺。

**Do you experience any of the following: cold feet, numbness, burning, tingling, or any abnormal sensation in the foot and/or ankle.**

如果有，是什麼呢？ 您是如何得知我們的診所的？

**If so, which ones?** _____ **How did you hear about our office?** _____

首選藥房 地址 電話

**Preferred Pharmacy:** _____ **Address:** _____ **Phone #:** _____

**Are you Currently or have you ever been treated for the following:**

| 是 Yes | 否 No | 身體健康狀況 Condition | 是 Yes | 否 No | 身體健康狀況 Condition |
|---|---|---|---|---|---|
| ☐ | ☐ | **Asthma** 哮踹 | ☐ | ☐ | **Sleep disorders** 睡眠障礙 |
| ☐ | ☐ | **Bleeding disorders** 出血性疾病 | ☐ | ☐ | **Stroke** 中風 |
| ☐ | ☐ | **High Blood pressure** 高血壓 | ☐ | ☐ | **Any Surgery** 手術 |
| ☐ | ☐ | **Ear/sinus problem** 耳朵/鼻竇問題 | ☐ | ☐ | **Foot or leg injury** 腳傷 |
| ☐ | ☐ | **Diabetes** 糖尿病 | ☐ | ☐ | **Serious injury** 重傷 |
| ☐ | ☐ | **COPD** 慢性阻塞性肺病 | ☐ | ☐ | **Thyroid disease** 甲狀腺疾病 |

# Yuen Podiatry PC

**Dr. Shing Cheung Yuen DPM 袁誠璋醫生**

**Dr. Qian Xu DPM 徐芊醫生**

*Foot and Ankle Specialists* 腳科專科醫生

1810 College Point Blvd., Flushing, NY, 11356 85-10 Queens Blvd., Elmhurst, NY, 11373 2044 86th Street, Brooklyn, NY, 11214

Tel: (646) 520- 7027 Fax: (929) 242-4312

| 是 Yes | 否 No | Condition | 是 Yes | 否 No | Condition |
|---|---|---|---|---|---|
| ☐ | ☐ | **Gastro-intestinal problems** 腸胃問題 | ☐ | ☐ | **Bunions** 拇趾外翻 |
| ☐ | ☐ | **Heart disease** 心臟疾病 | ☐ | ☐ | **Foot skin problems** 腳皮膚問題 |
| ☐ | ☐ | **Kidney disease** 腎臟疾病 | ☐ | ☐ | **Toenail problems** 腳甲問題 |
| ☐ | ☐ | **Learning disorders** 學習障礙 | ☐ | ☐ | **Liver disease** 肝病 |
| ☐ | ☐ | **Menstrual problems** 心理問題 | ☐ | ☐ | **Rheumatic fever** 風濕熱 |
| ☐ | ☐ | **Musculo-skeletal** 肌肉骨骼問題 | ☐ | ☐ | **Gout** 痛風 |
| ☐ | ☐ | **Psychological/psychiatric** 心理問題 | ☐ | ☐ | **Bursitis** 滑囊炎 |
| ☐ | ☐ | **Seizures** 癲癇 | ☐ | ☐ | **Varicose veins** 靜脈曲張 |
| ☐ | ☐ | **Sickle cell disease** 鐮狀細胞性貧血症 | ☐ | ☐ | **Arthritis** 關節炎 |

家族病史
**Family History:**
你家人目前或曾接受治療的任何醫療狀況： 與你的關係
**Any medical conditions your family currently or have been treated for: _____ Relationship to you: _____**

手術歷史
**Surgical History: 1: _____ 2: _____ 3: _____**

個人歷史 抽煙 有 沒有
**Social history: Smoking** ☐ ☐
**Yes No**

如有抽煙， 每天抽多少? 抽了多久？ 如戒掉了，戒了多久？
**If so, how many pack per day and for how long? _____ If quit, for how long?**

請列出你現在服的所有藥物，包括非處方藥和草本藥物。
**List all medications you are currently taking, include over-the-counter drugs and herbal supplements:**

| 藥物名稱 **Medication** | 劑量 **Dosage** | 服食原因 **Reason** |
|---|---|---|
| | | |
| | | |

敏感：局部麻醉藥，青黴素(盤尼西林)，可待因，阿司匹林，碘，膠帶，乳膠，磺胺藥物材料或其他。
**Allergies: (local anesthetics, penicillin, codeine, aspirin, iodine, adhesive tape, latex, sulfa-drugs materials, or others.**

**I hereby give Dr. Shing Cheung Yuen and Dr. Xu Qian to administer treatment and to perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my foot and ankle condition. I also hereby assign to the above-named physicians all benefits provided by my insurance company policy or policies for medical or surgical care. I understand that I am financially responsible for any balance due on my account.**

**X**_____ _____

**Signature of patient (or parent, if minor)** **Date**

# Yuen Podiatry PC

**Dr. Shing Cheung Yuen DPM 袁誠璋醫生**

**Dr. Qian Xu DPM 徐芊醫生**

*Foot and Ankle Specialists* 腳科專科醫生

1810 College Point Blvd., Flushing, NY, 11356 85-10 Queens Blvd., Elmhurst, NY, 11373 2044 86th Street, Brooklyn, NY, 11214
Tel: (646) 520- 7027 Fax: (929) 242-4312

**ACKNOWLEDGEMENT OF RECEIPT OF SUMMARY**
**NOTICE OF PRIVACY PRACTICES**

**Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The notice contains participant rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our notice, you may obtain a revised copy by contacting our office at 1810 College Point Blvd., Flushing, NY 11356; 85-10 Queens Blvd, Elmhurst, NY, 11373; 2044 86th Street, Brooklyn, NY, 11214.**

**You have the right to request that we restrict how protected information about you is used or disclosed for treatment, payment, or healthcare operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.**
**By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke the Consent in writing, signed by you. However, such a renovation shall not affect any disclosures we have already made in reliance on your prior Consent.**

**The participant understands that:**

- **Protected health information may be disclosed or used for treatment, payment, or health care operations.**
- **Yuen Podiatry PC have Notice of Privacy Practices and that the participant has the opportunity to review this notice.**
- **Yuen Podiatry PC reserves the right to change the Notice of Privacy Practices.**
- **The Participant has the right to request restrictions to the uses of their information but does not have to agree to these restrictions.**
- **The participant may revoke this Consent in writing at any time and full disclosures will then cease.**

**I have received a copy of the Summary Notice of Privacy Practices. I understand that I may also request a copy of the practice's complete Notice of Privacy Practices if I so desire.**

_____
**Name of Participant (Print)** 病人姓名

_____ _____
**Signature of Participant** 病人簽名 **Date** 日期

_____ _____
**Signature of Participant Representative** **Date** 日期
**(Required if participant is a minor or an adult who is unable to sign this form)**
代表人簽名（如病人是未成年的）

_____ _____
**Relationship of Participant Representative to Participant** **Print Name** 姓名
代表人和病人的關係

**X**_____ _____
**Signature of patient (or parent, if minor)** 病人簽名 **Date** 日期