the clinic *by International Rehabilitation Specialists*
118 Jiashan Rd. Building B, Floor 5, Suite A501
Shanghai - 200031 I CHINA
T: (+86.21) 336.888.01
F: (+86.21) 336.888.92

www.theclinic.international

BARCODE
(ADMINISTRATIVE USE)

PATIENT HISTORY 病史

(To be completed up by patient 由病人填写)

Date 日期 DD / 日: _____ MM / 月: _____ YYYY / 年: _____ Occupation 职业 _____

Family Name 姓 _____ First Name 名字 _____ Sex 性别 ☐ F / 女 ☐ M / 男

Birth Date 出生日期 DD / 日: _____ MM / 月: _____ YYYY / 年: _____ Ethnicity 种族 _____

Marital Status 婚姻状况 ☐ Married/已婚 ☐ Single/单 ☐ Widowed/寡 Country of origin 国籍 _____

Number of Children / Family here 在中国的子女/家人人数 ____/_____ Estimated time to stay in China 预计在中国停留的时间 _____

1. Family History 家族史: Have you or any of your immediate relatives (mother, father, siblings, grandparents, spouse) experienced any of the following (before age 65)? 你或者你的家人(母亲、父亲、兄弟姐妹、祖父母、配偶)有以下的疾病史吗(65岁之前)?

☐ Alcoholism 酗酒	☐ Psychiatric disorders 精神	☐ Depression 消沉	☐ Stroke 冲程	☐ Heart disease 心脏病
☐ Diabetes 糖尿病	☐ Thyroid disease 甲状腺疾	☐ Drug abuse 病药物成	☐ Cancer 癌肿	☐ Asthma 哮喘
☐ Epilepsy 癫痫	☐ High blood pressure 高血	☐ Glaucoma 青光眼	☐ Ulcer 溃疡	☐ Genetic disease 遗传疾

2. Have you ever had any of the following 你曾经有过下列疾病吗:

☐ Anemia 贫血	☐ Kidney Problems 肾脏疾病	☐ Chest Pain 胸痛
☐ Diabetes 糖尿病	☐ Severe Headache 剧烈头痛	☐ Eczema 湿疹
☐ Epilepsy/Seizures 癫痫/癫痫发作	☐ Difficulty Breathing 呼吸困难	☐ Frequent Indigestion 反复消化不良
☐ Hepatitis 肝炎	☐ Radiation Treatment 放射疗法	☐ Blood in Stool 便中带血
☐ Abnormal Bleeding 异常出血	☐ Ulcers/Colitis 溃疡/结肠炎	☐ Bladder Problem 膀胱疾患
☐ Congenital Heart Defect 先天性心脏病	☐ Asthma/Arthritis 哮喘/关节炎	☐ Skin Cancer 皮肤癌
☐ Rheumatic Fever 风湿症	☐ Sinus Problems 鼻窦炎	☐ Back Pain 背疼
☐ Abnormal Heart Condition 心脏疾病	☐ Emphysema 肺气肿	☐ Night Sweats 盗汗
☐ Abnormal Blood Pressure 异常血压 S_____/D_____	☐ Cancer/Chemotherapy 癌症/化疗	☐ Weight Loss 体重降低
☐ Drugs/Alcohol Abuse 药物/酒精成瘾	☐ HIV/AIDS 艾滋病	

3. For women. Are you pregnant? 如果您是女性，您有怀孕吗？ ☐ Yes 是 ☐ No 否

4. For men. When was your last PSA (Prostate-Specific Antigen Count) Test? 如果您是男性，您的上一次PSA（前列腺特异抗原数）测试是何时？ DD / 日: _____ MM / 月: _____ YYYY / 年: _____

5. Please list any hospitalization, surgeries, implants (i.e. rods, screws, pacemaker, electronic objects, heart valve(s), major illnesses (with dates):
请列出你以往住院、病史、手术史任何植入性治疗（例如：螺丝钉，心脏起搏器，心脏瓣膜疾病）及主要疾患(包括日期):

_____

6. Please list any medications you are taking currently at present (including birth control and vitamins):
请列出你目前正在服用的药物(包括避孕药和维生素)

_____

7. Please list any known food and medication allergies:
请列出你已知道的食物和药品过敏史

_____

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8. Life Style 生活习惯 :

Do you smoke 你吸烟吗?	☐ Yes 是 ☐ No 否	If YES, how much? 如果是，多少支一天?
	☐ Yes, but stopped 是，但已	How many sticks/days before stopping? 戒烟前每天吸几支?
Do you drink alcohol? 你饮酒	☐ Yes 是	How many units per week? 每周喝多少?
	☐ No 否	If no, did you ever drink heavily? 如果不，你曾经酗酒吗?
Do you exercise? 你经常锻炼	☐ Yes 是 ☐ No 否	If yes, how often? 如果是，多久一次?
Do you sleep well? 你的睡眠好	☐ Yes 是 ☐ No 否	If no, describe 如果否，请描述

GENERAL CONSENT FOR TREATMENT 就医告知书

致门诊治疗和急诊治疗的患者:

本人自愿要求**上海赟动康复医学门诊部 (the clinic)** 给予本人相关的医疗服务以及同意他们的相关医务人员对本人进行医疗诊断以及治疗。本人知晓这些医疗服务将由医生,医疗辅助临床医生、护士和其他卫生保健/健康顾问等提供。本人知晓治疗不一定达到本人预期的结果，并不对此进行任何追责。本人知晓本人的权利和义务会持续到医疗服务关系终止。本人知晓本人接受的检查会包含一些常规的治疗与检查：如抽血、体格检查、药物、x片以及局部麻醉和其他非入侵治疗程序其他与诊断相关的检查和治疗，本人同意接受诊断和治疗所需要的程序，并积极配合和遵循相关医务人员进行相关医疗服务。本人知晓**上海赟动康复医学门诊部 (the clinic)**符合中国当地法律法规，地方政府法规可能要求上报本人的健康状况给当地卫生部门。**上海赟动康复医学门诊部 (the clinic)**是由国际公司合作组织管理开展，其行为完全符合中国法律。本人同意关于任何门诊部的治疗的任何争议、索赔以及纠纷完全依照中华人民共和国法律，如果存在诉讼，仅接受中华人民共和国或者香港特别行政区的法院和法庭，同时排除其他任何国家的法院和法庭。

For patients seeking out-patient and / or emergency services:

I am asking for medical care and treatment at **the clinic** *by international rehabilitation specialists* (***the clinic***) and agree to accept the services at their facilities or partner facilities which may diagnose a medical condition, procedures to treat my condition and medical care. I understand that these services will be provided to me by physicians, allied health clinicians, nurses and other health care / wellness consultants and providers. I understand that medical services I receive in ***the clinic*** may not lead to the results I expected, and I have not been given any guarantees as to the results of the services I will receive. I understand that my agreement to accept these services will remain in effect unless I say that I no longer want these services or until my treatment at their facilities is completed. I understand that my agreement to accept these services is called a General Consent and that it includes any routine procedure(s) or treatment(s) such as blood drawing, physical examination, administration of medication(s), taking X-rays, and other necessary diagnostic and treatment procedure, use of local anesthesia and other non-invasive procedures. I agree to accept the diagnostic and treatment procedures, and cooperate with the medical and allied health providers to complete the treatment or health care. I also agree to follow the operation management regulation and rules of their facilities and partner facilities. I understand that ***the clinic*** complies with local Chinese laws and that local governmental regulations may require that in certain circumstances information regarding my health be reported to the local Health Bureau. ***the clinic*** is an internationally managed Joint Venture organization conducting its activities in accordance with Chinese Law. I agree that any Controversy, Claim or Dispute relating to treatment at ***the clinic*** will be governed and interpreted exclusively in accordance with the laws of the People's Republic of China. I also agree that all controversies shall be litigated, if at all, only in the courts of the People's Republic of China or Hong Kong, and to the exclusion of the courts of any other country.

_____ DD / 日: _____ MM / 月: _____ YYYY / 年: _____

Signature of Patient / 患者签名

If the patient cannot consent for him/herself, the signature of either the **health care agent or legal guardian** who is acting on behalf of the patient, or the **patient's next of kin** who is consenting to the treatment for the patient, must be obtained (must provide authorizing document). 如果病人本人不能确认签名，必须由其医疗代理人或者法定监护人代表签字，病人的直系亲属也可以进行签署**（必须提供授权文档）**

_____ DD / 日: _____ MM / 月: _____ YYYY / 年: _____

Signature & Relationship of Next of Kin
(Place a copy of the relationship document in the medical record)
签名以及亲属关节**（附上医疗记录中的关系复印件）**