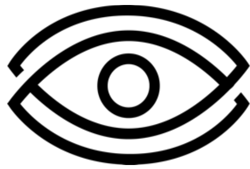

Vincent Lam, M.D.
1740 South St. Suite 400
Philadelphia, PA 19146
TEL:267.607.6888 Fax: 267.393.4310

Patient Name (病人名字) ____________________ Date of Birth (出生日期) ____________________

1. Date of last eye exam (上次看眼科什么时候)____________________
2. Are you currently in a good health (你目前身体状况是否良好)? Yes ☐ No ☐____________________
3. Are you currently taking any medications (现阶段是否服用任何药物)? No ☐ Yes ☐____________________
4. Are you allergic to any medications (是否都任何药物过感)? No ☐ Yes ☐____________________
5. Have you had any serious illness, operation or been hospitalized before(是否曾有重大疾病/手术/住院)?
____

Please indicate if you have had any of the following disease or problems: 你是否曾经或现在有以下疾病：

	Yes	No		Yes	No
Ears, Nose, Throat 耳鼻喉	☐	☐	Respiratory 呼吸	☐	☐
Diabetes 糖尿病	☐	☐	Gastrointestinal 肠胃病	☐	☐
Hypertension 高血压	☐	☐	Kidney, Genital, Bladder 肾病，泌尿	☐	☐
Thyroid Problems 甲状腺问题	☐	☐	Muscles, Bones, Joints 肌肉骨骼关节	☐	☐
Cardiovascular Disease 心脏问题	☐	☐	Skin Problems 皮肤病	☐	☐
Hepatitis 肝炎	☐	☐	Neurological 神经系统	☐	☐
Emphysema 肺气肿	☐	☐	Psychiatric 精神状态	☐	☐
Astham 哮喘病	☐	☐	Blood Diseases 血液疾病	☐	☐
Anemia 贫血	☐	☐	Allergic/ Immunologic 过敏/ 免疫系统	☐	☐
Rheumatoid Arthritis 风湿症关节炎	☐	☐	Cancer/Chemotherapy/Radiation Treat 癌症	☐	☐
Other Disease (其他疾病请列明), Please State:					
[ ]Smoking 吸烟 [ ]Alcohol 酗酒 [ ]Illicit Drugs 禁药					
Family Histroy (亲属病史): [ ]Glaucoma 青光眼 [ ]Cataract 白内障 [ ]Retinal Detachment 视网膜脱落 [ ]Blindness 失明 [ ]Macular Degeneration 黄斑病变 [ ]Diabetes 糖尿病 [ ]Hypertension 高血压 [ ]Cancer 癌症 [ ]Arthritis 关节炎 [ ]Heart Disease 心脏病 [ ]Other 其他:					

Plese inform City Ophthalmology of any changes in your health and medication. 请告知我们有关您健康跟用药的改动。

This form was completely by(该表格内容由谁填写): [ ]Patient 病人 [ ]Family 家属 [ ]Technician 医务人员
Signature of Technician(医务人员签名) ____________________ Reviewed by: ____________________
Physician’s Signature(医生签名) : ____________________ Date: ____________________