Yiu Fun Derek Lee M.D.

2440 S. Hacienda Blvd #116
Hacienda Heights, CA 91745

PATIENT INFORMATION

PATIENT NAME: _____ _____
Last name 姓 First name 名 Middle initial中文名字

SOCIAL SECURITY NO._____ **DRIVER' SLICENSE NO.:** _____
工卡號碼 駕照號碼

MARITAL STATUS: S_____ M_____ DIV_____ SEP_____ **DATE OF BIRTH:** _____ **AGE:** _____
婚姻狀況： 單身 結婚 離婚 分居 生日 年齡

HOME ADDRESS: _____
住址 Number Street City State Zip
(Can we send letter to this address? If NO, please mark Here( ). How can we contact _____

HOME PHONE: ( )_____ **WORK PHONE:** ( )_____ **SEX:** __F__M
電話號碼 公司電話號碼 性別

EMPLOYED BY: _____ **OCCUPPATION:** _____
顧主 職位

WORK ADDRESS: _____
工作地址 Number Street City State Zip

IN CASE OF EMERGENCY CALL: _____ (____)_____
緊急情況請找 Name姓名 Phone 電話 Relationship關係

REFERRED BY: _____**PRIMARY CARE PHYSICIAN:**_____
介紹人 家庭醫生

HOW DO YOU KNOW OUR OFFICE? ( )PCP( ) AM1430 ( )YELLOW PAGE ( ) SIGN ( )OTHERS_____
您是如何知道我們診所的呢？

MEDICAL INSURANCE: ( ) NONE ( ) HMO ( ) MEDI-CAL ( ) MEDI-CARE ( ) PPO ( ) OTHER: ___
醫療保險

ASSIGNMENT OF BENEFITS:

I hereby authorize Attending Physician to apply for benefits on my behalf for covered services rendered by him/her or by his/her order. I request that payment from my insurance company be made directly to the above named physician and take the responsibility for the payment of the bill not covered by my insurance.

I certify that the information I have reported with regard to my insurance coverage is correct.

I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company at any time in writing.

Signature: _____ **Date:** _____
病人簽名 **(Patient, Parent, or Guardian)** 日期

Yiu Fun Derek Lee, M. D.,Inc.
A Professional Corporation
2440 S. Hacienda Blvd #116 Hacienda Heights, CA 91745
Tel: (626) 369-1886 Fax: (626) 369-2557

Record Release Authorization

To: _____

_____

_____

_____

I hereby authorize you to release to:

Yiu Fun Derek Lee M.D.,Inc.
2440 S. Hacienda Blvd #116
Hacienda Heights, CA 91745

The complete history records in your possession concerning my illness and/or treatment during the period from _____ to _____.

Name: _____

Date of Birth: _____ Social Security No._____

Address: _____

Signature: _____ Date: _____
If other than patient, please indicate relationship

Yiu Fun Derek Lee M.D.,Inc.
A Professional Corporation and its affiliated physicians
2440 S. Hacienda Blvd #116, Hacienda Heights, CA 91745
Tel: (626) 369-1886 Fax: (626) 369-2557

PATIENT PARTNERSHIP PLAN

Dear Patient:
Welcome to our practice. We intend to provide you the care and service that you expect and deserve. Achieving you best possible health requires a "partnership" between and you and your doctor. As our "partner in health", we ask you to help us in the following ways:

Schedule Visits with My Doctor for Routine Physical Exams and Other Recommended Health Screenings

I understand that my doctor will explain to me which regular health screenings are appropriate for my age, gender, and personal and family history. I understand I will need to complete there recommended health screenings (mammogram, immunization, pap smears, etc.). These health Screenings are tests that can help detect life-threatening diseases and conditions. If I visit my doctor only for treatment of immediate problems and forget to arrange for regular health screenings, I put myself at risk of letting serious health problems go undetected. I will schedule regular visits with my doctor to complete my physical exam and to discuss these health screenings.

Keep Follow-up Appointments and Reschedule Missed Appointments

I understand that my doctor will want to know how my condition progresses after I leave the office. Returning to my doctor on time gives him or her chance to check my condition and my response to treatment. During a follow-up appointment, my doctor might order tests, refer me to a specialist, prescribe medication, or even discover and treat a serious health condition. If I miss an appointment and don't reschedule, I run the risk that my physician will not be able to detect and treat a serous health condition. I will take every effort to reschedule missed appointments as soon as possible.

Call the Office When I Do Not Hear the Results of Labs and Other Tests

I understand that my physician's goal is to report my lab and test results to me as soon as possible. However, if I do not hear from my physician's office within the time specified, I will call the office for my test results.

Inform My Doctor If I Decide *NOT* to Follow His or Her Recommended Treatment Plan

I understand that after examining me, my doctor may make certain recommendations based on what he or she assesses is best for my health. This might include prescribing medication, referring me to a specialist, ordering labs and tests, or even asking me to return to the office within a certain period of time. I understand that NOT following my treatment plan can have serious negative effects on my health and fetal will being I will let my doctor know whether I decide NOT to follow his or her recommendations so that he or she may fully inform me of any risks associated with my decision to delay or effuse treatment. Doctor has the right to terminate the relationship at any time if patient fail to comply with DOCTOR"S recommendation.

Thank you for your partnership. As our patient, you have the right to be informed about your health care. We invite, at any time, to ask questions, report symptoms, or discuss any concerns you my have. If you need more information about your health condition, please ask.

Patient Signature *Date* *Physician Signature*

Yiu Fun Derek Lee M.D.,Inc.
A Professional Corporation
Obstetrics /Gynecology/Infertility
2440 S. Hacienda Blvd #116
Hacienda Heights, CA 91745
(626)369-1886

Effective as of April 14, 2003

Notice of Privacy Practices

To our patients. This notice describes how health information about you, as a patient of this practice, may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.

We realize that these laws are complicated, but we must provide you with the following important information:

Use and disclosure of your health information in certain special circumstances.

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to don so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization abie to help prevent the threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of law enforcement official.
8. For Workers Compensation and similar programs.

Your rights regarding your health information

1. Communications. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.

2. You can request a restriction in our use of disclosure of your health information of treatment, payment, or health care operation. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to the address below.
4. You may ask us to amend your health care information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to the address below. You must provide us with a reason that supports your request for an amendment.
5. Right to a copy of this notice. You are entitled to receive a copy or this Notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time.
6. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services, Office of Civil Rights, 200 Independence Ave. SW, Washington, D.C. 20201 or by phone 1-877-696-6775. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
7. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our health information privacy policies, please contact our office at:

Yiu Fun Derek Lee M.D.,Inc
Attn: Privacy Officer
2440 S. Hacienda Blvd #116
Hacienda Heights, CA 91745
Phone (626) 369-1886
Fax (626) 369-2557

I hereby acknowledge that I have read Dr. Lee's Notice of Privacy Practice.

_____ _____

Printed name of Patient Signature

_____

Date

Yiu Fun Derek Lee, M. D.

2440 S. Hacienda Blvd #116 , Hacienda Heights, CA 91745
Tel: (626) 369-1886 Fax: (626) 369-2557

Name:_____
M.R.#_____

OB/GYN QUESTIONNAIRE

1. CHIEF COMPLAINT:

Reason for this visit
你今天來看醫生的原因是:_____

How old are you?
你今年幾歲？_____

2. PAST HISTORY:

A. OB HISTORY: Total number of pregnancies
你懷孕的次數 _____

Full term babies
有幾個 足月生的嬰兒_____

Preterm babies (before 37 weeks)
有幾個早產的嬰兒 _____

Abortions /Miscarriage
有幾次人工流產/小產_____

Living Children
現在有幾個孩子_____

B. GYNCOLOGICAL AND MENSTRUAL HISTORY

Do you still have periods? Yes No
你現在還有月經嗎？ 是_____ 没有_____

When was your last period?
你最後一次月經是甚麼時候？_____

At what age did you begin having periods?
你幾歲來第一次月經？_____

How many days from the beginning of one period to the beginning of your next period?
你的月經周期是多少天？ _____

How many days do you bleed when you have your period?
你的月經有多少天流血？ _____

Are your periods: LIGHT MODERATE HEAVY
你的月經流血量： 很少 正常 很多

Do you bleed between periods? Yes No
在月經周期之間會流血嗎？ 有_____ 没有 _____

What methods of contraception have you used?
你曾經用過哪種避孕法來避孕？ _____

Have you ever had any trouble with any method of birth control?
當你在使用任何一種避孕法時,你是否有任何的不適？ _____

What is your present method?
你現在是用哪種避孕法避孕？ _____

C. SEXUAL HISTORY

Are you sexually active? Yes No
你現在有性生活嗎？ 有_____ 没有_____

How long have you been with your present sexual partner?
你跟你現在的性伴侶一起有多久？

How many sexual partners do you have at this time?
你現在有幾個性伴侶？ _____

Does your partner have other partmers? Yes No
你的性伴侶有另外的性伴侶嗎？ 有_____ 没有 _____

		Yes 有	No 没有
Chlamydia	披衣菌	_____	_____
Gonorrhea	淋病	_____	_____
Syphilis	梅毒	_____	_____
Herpes	疱疹	_____	_____
Warts	疣菌	_____	_____

Do you leak urine when you cough, sneeze or walk? Yes No
當你咳嗽，打噴嚏或是行走時, 是否會有小便溺出？ _____ _____

Does it hurt or burn when you urinate?
當你小便時, 是否覺得疼痛或是有灼熱的感覺？ _____ _____

When was your last Pap Smear? Was it normal?
你上一次的子宮塗片檢查是甚麼時候？_____ 結果是否正常？_____

Have you ever had on abnormal Par Smear? When?
你是否有過不正常的子宮塗片檢查結果呢？_____ 甚麼時候？_____

Do you have bleeding or pain with intercourse? Yes No
當你行房時，是否有流血或是疼痛的現象？ 是 没有

Do you currently have an unusual vaginal discharge? Yes No
你現在有没有不在常的陰道分泌物？ 是 没有

When your mother was pregnant with you, did she take hormones (DES) to prevent miscarriage? Yes No
當你媽媽懷有你的時候，她有没有服用荷爾蒙來避免流產？ 是 没有

D. MEDICAL HISTORY

Yes 有	No 没有		
_____	_____	High blood pressure	高血壓
_____	_____	Diabetes	糖尿病
_____	_____	Liver disease	肝病
_____	_____	Heart disease	心臟病
_____	_____	Kidney problems	腎病
_____	_____	Blood transfusion	輸血
_____	_____	Others	其它的病歷

E. SURGICAL HISTORY:

Have you ever been hospitalized for illness or surgery? Yes No
你是否曾經因爲生病或是手術而住院嗎？ 有 没有
(if Yes,)如果是，
Name of hospital
醫院的名字 _____
Reason
住院的原因 _____

3. PERSONAL HISTORY:

Yes 有	No 没有	
_____	_____	Do you smoke? How much a day? 你抽煙嗎？ 一天抽幾次？_____
_____	_____	Do You drink alcohol? 你喝酒嗎？

Yes	No	
_____	_____	Do you use drugs now or have you in the past? What? 你現在或是以前有使用藥物的習慣嗎？是甚麼藥？ _____
_____	_____	HIV / AIDS? 愛滋菌帶原者/愛滋病患
_____	_____	Have you ever had a reaction to medications such as penicilin, sulfa, etc? If yes, please list and describe. 你是否對任何藥物有過敏反應，例如盤尼西林，磺 安藥，等等。 如果有， 請寫下來並且說明。

_____

4. FAMILY HISTORY

CIRCLE ONE: MARRIED 已婚 DIVORCED 離婚 WIDOWED 寡居 SINGLE 單身

Have anyone in your family, including parents, sisters or brothers, grandparents, aunts and uncles, ever had any of the following?
在你的家屬中，包括你的父母親，兄弟姐妹，祖父母，阿姨（姑姑）和 舅舅（叔叔）有以下的疾病？

Yes 有	No 没有		
_____	_____	High blood pressure	高血壓
_____	_____	Heart disease	心臟病
_____	_____	Stroke	中風
_____	_____	Diabetes	糖尿病
_____	_____	Cancer	癌症
_____	_____	Others	其它

5. Are you taking any medication? Yes No
(If Yes, Please list the name of the medicine)

您現在有没有服用任何的藥劑。 有 没有
(如果有，請寫出藥劑的名稱)

_____

_____