

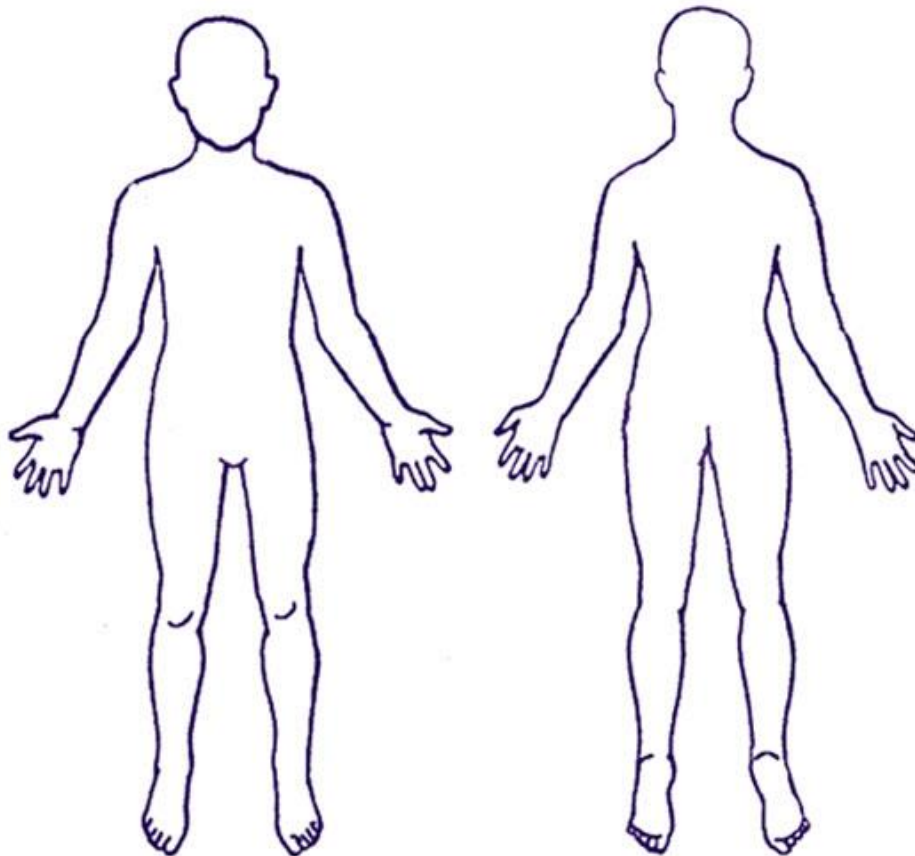
English	Chinese / 英语
<p><a href="#">New Patient Questionnaire for newly arrived migrants in the UK</a></p> <p>Everyone has a right to register with a GP. You do not need proof of address, immigration status, ID or an NHS number to register with a GP.</p> <p>This questionnaire is to collect information about your health so that the health professionals at your GP practice can understand what support, treatment and specialist services you may need in accordance with the confidentiality and data sharing policies of the National Health Service.</p> <p>Your GP will not disclose any information you provide for purposes other than your direct care unless: you have consented (e.g. to support medical research); or they are required to do so by law (e.g. to protect other people from serious harm); or because there is an overriding public interest (e.g. you are suffering from a communicable disease). Further information about how your GP will use your information is available from your GP practice.</p> <p>Return your answers to your GP practice.</p>	<p>针对英国新移民的全新患者问卷调查</p> <p>每个人都有权进行全科医生注册。进行全科医生注册时不需要地址证明、移民身份、身份证，或 NHS 号码。</p> <p>本问卷旨在收集您健康的信息，以便您所在诊所的医疗专业人员能够根据英国国家医疗服务体系的保密和数据共享政策了解您所需的支持、治疗，和专业服务。</p> <p>除了对您进行直接护理时，您的全科医生不会披露您的任何信息，但以下情况除外：已获取您的同意（例如支持医学研究）；或者法律要求他们必须披露信息（例如，为了保护他人免受严重伤害时）；或者涉及到极其重要的公共利益时（例如，您患有传染病）。关于全科医生会如何使用您的个人信息，您可以在您所在的诊所查看更多相关资料</p> <p>将您的答案提交给您所在的诊所。</p>
<p><a href="#">Section one: Personal details</a></p>	<p>第一部分：个人资料</p>
<p>Full name:</p>	<p>姓名：</p>
<p>Address:</p>	<p>地址：</p>
<p>Telephone number:</p>	<p>手机：</p>
<p>Email address:</p>	<p>邮箱：</p>

<b>Please complete all questions and tick all the answers that apply to you.</b>	请完成所有的问题并勾选符合您个人情况的答案。
1.1 Date questionnaire completed:	1.1 问卷完成日期：
1.2 Which of the following best describes you? <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other <input type="checkbox"/> Prefer not to say	1.2 哪项描述符合您个人情况？ <input type="checkbox"/> 男性 <input type="checkbox"/> 女性 <input type="checkbox"/> 其他 <input type="checkbox"/> 不想说
1.3 Is this the same gender you were given at birth? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Prefer not to say	1.3 此性别是否与你出生是的性别相同？ <input type="checkbox"/> 否 <input type="checkbox"/> 是 <input type="checkbox"/> 不想说
1.4 Date of birth: Date _____ Month _____ Year _____	1.4 生日： 日 _____ 月 _____ 年 _____
1.5 Religion: <input type="checkbox"/> Buddhist <input type="checkbox"/> Christian <input type="checkbox"/> Hindu <input type="checkbox"/> Jewish <input type="checkbox"/> Muslim <input type="checkbox"/> Sikh <input type="checkbox"/> Other religion <input type="checkbox"/> No religion	1.5 宗教： <input type="checkbox"/> 佛教 <input type="checkbox"/> 基督教 <input type="checkbox"/> 印度教 <input type="checkbox"/> 犹太教 <input type="checkbox"/> 伊斯兰教 <input type="checkbox"/> 锡克教 <input type="checkbox"/> 其他 <input type="checkbox"/> 无
1.6 Marital status: <input type="checkbox"/> Married/civil partner <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> None of the above	1.6 <input type="checkbox"/> 已婚/民事伴侣 <input type="checkbox"/> 离婚 <input type="checkbox"/> 丧偶 <input type="checkbox"/> 以上均不是
1.7 Sexual Orientation: <input type="checkbox"/> Heterosexual (attracted to the opposite sex) <input type="checkbox"/> Homosexual (attracted to the same sex)	1.7 性取向： <input type="checkbox"/> 异性恋（喜欢异性） <input type="checkbox"/> 同性恋（喜欢同性） <input type="checkbox"/> 双性恋（男女均喜欢）

<input type="checkbox"/> Bisexual (attracted to males and females) <input type="checkbox"/> Prefer not to say <input type="checkbox"/> Other	<input type="checkbox"/> 不想说 <input type="checkbox"/> 其他
<p>1.8 Main spoken language:</p> <input type="checkbox"/> Albanian <input type="checkbox"/> Russian <input type="checkbox"/> Arabic <input type="checkbox"/> Tigrinya <input type="checkbox"/> Dari <input type="checkbox"/> Ukrainian <input type="checkbox"/> English <input type="checkbox"/> Urdu <input type="checkbox"/> Persian <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other	<p>1.8 主要语言</p> <input type="checkbox"/> 阿尔巴尼亚语 <input type="checkbox"/> 俄语 <input type="checkbox"/> 阿拉伯语 <input type="checkbox"/> 提格里尼亚语 <input type="checkbox"/> 达里语 <input type="checkbox"/> 乌克兰语 <input type="checkbox"/> 英语 <input type="checkbox"/> 乌尔都语 <input type="checkbox"/> 波斯语 <input type="checkbox"/> 越南语 <input type="checkbox"/> 其他
<p>1.9 Second spoken language:</p> <input type="checkbox"/> Albanian <input type="checkbox"/> Russian <input type="checkbox"/> Arabic <input type="checkbox"/> Tigrinya <input type="checkbox"/> Dari <input type="checkbox"/> Ukrainian <input type="checkbox"/> English <input type="checkbox"/> Urdu <input type="checkbox"/> Persian <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other <input type="checkbox"/> None	<p>1.9 第二语言</p> <input type="checkbox"/> 阿尔巴尼亚语 <input type="checkbox"/> 俄语 <input type="checkbox"/> 阿拉伯语 <input type="checkbox"/> 提格里尼亚 <input type="checkbox"/> 达里语 <input type="checkbox"/> 乌克兰语 <input type="checkbox"/> 英语 <input type="checkbox"/> 乌尔都语 <input type="checkbox"/> 波斯语 <input type="checkbox"/> 越南语 <input type="checkbox"/> 其他 <input type="checkbox"/> 无
<p>1.10 Do you need an interpreter?</p> <input type="checkbox"/> No <input type="checkbox"/> Yes	<p>1.10 您需要翻译吗?</p> <input type="checkbox"/> 否 <input type="checkbox"/> 是
<p>1.11 Would you prefer a male or a female interpreter? Please be aware that interpreter availability might mean it is not always possible to meet your preference.</p> <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> I don't mind	<p>1.11 您需要男性译员还是女性译员? 请知悉, 译员有时可能并不符合您的所有要求</p> <input type="checkbox"/> 男性 <input type="checkbox"/> 女性 <input type="checkbox"/> 我不介意
<p>1.12 Are you able to read in your own language?</p> <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> I have difficulty reading	<p>1.12 您能阅读您所用的语言吗?</p> <input type="checkbox"/> 否 <input type="checkbox"/> 是 <input type="checkbox"/> 我有阅读障碍
<p>1.13 Are you able to write in your own language?</p> <input type="checkbox"/> No	<p>1.13 您能书写您所用的语言吗?</p> <input type="checkbox"/> 否 <input type="checkbox"/> 是

<input type="checkbox"/> Yes <input type="checkbox"/> I have difficulty writing	<input type="checkbox"/> 我有书写障碍								
1.14 Do you need sign language support? <input type="checkbox"/> No <input type="checkbox"/> Yes	1.14 您需要手语翻译吗? <input type="checkbox"/> 否 <input type="checkbox"/> 是								
1.15 Please give details of your next of kin and/or someone we can contact in an emergency:  <table border="1" data-bbox="150 613 801 1794"> <tr> <td data-bbox="150 613 432 1202"> Name:   Contact telephone number:   Address: </td> <td data-bbox="432 613 801 1202"> <u>Next of kin</u> </td> </tr> <tr> <td data-bbox="150 1202 432 1794"> Name:   Contact telephone number:   Address: </td> <td data-bbox="432 1202 801 1794"> Emergency contact (if different) </td> </tr> </table>	Name:  Contact telephone number:  Address:	<u>Next of kin</u>	Name:  Contact telephone number:  Address:	Emergency contact (if different)	1.15 请提供您的近亲属和/或在紧急情况下我们可以联系的人的信息  <table border="1" data-bbox="823 586 1489 1646"> <tr> <td data-bbox="823 586 1109 1115"> 姓名：   电话：   地址： </td> <td data-bbox="1109 586 1489 1115"> <u>近亲属</u> </td> </tr> <tr> <td data-bbox="823 1115 1109 1646"> 姓名：   电话：   地址： </td> <td data-bbox="1109 1115 1489 1646"> 紧急联系方式（如与上述不同） </td> </tr> </table>	姓名：  电话：  地址：	<u>近亲属</u>	姓名：  电话：  地址：	紧急联系方式（如与上述不同）
Name:  Contact telephone number:  Address:	<u>Next of kin</u>								
Name:  Contact telephone number:  Address:	Emergency contact (if different)								
姓名：  电话：  地址：	<u>近亲属</u>								
姓名：  电话：  地址：	紧急联系方式（如与上述不同）								
Section two: Health questions	第二部分：健康问题								
2.1 Are you currently feeling unwell or ill? <input type="checkbox"/> No <input type="checkbox"/> Yes	2.1 您现在是否感觉身体不适? <input type="checkbox"/> 否 <input type="checkbox"/> 是								

<p>2.2 Do you need an urgent help for your health problem?</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes</p>	<p>2.2 您是否需要紧急治疗?</p> <p><input type="checkbox"/> 否</p> <p><input type="checkbox"/> 是</p>
<p>2.3 Do you currently have any of the following symptoms? <i>Please tick all that apply</i></p> <p><input type="checkbox"/> Weight loss</p> <p><input type="checkbox"/> Cough</p> <p><input type="checkbox"/> Coughing up blood</p> <p><input type="checkbox"/> Night sweats</p> <p><input type="checkbox"/> Extreme tiredness</p> <p><input type="checkbox"/> Breathing problems</p> <p><input type="checkbox"/> Fevers</p> <p><input type="checkbox"/> Diarrhoea</p> <p><input type="checkbox"/> Skin complaints or rashes</p> <p><input type="checkbox"/> Blood in your urine</p> <p><input type="checkbox"/> Blood in your stool</p> <p><input type="checkbox"/> Headache</p> <p><input type="checkbox"/> Pain</p> <p><input type="checkbox"/> Low mood</p> <p><input type="checkbox"/> Anxiety</p> <p><input type="checkbox"/> Distressing flashbacks or nightmares</p> <p><input type="checkbox"/> Difficulty sleeping</p> <p><input type="checkbox"/> Feeling like you can't control your thoughts or actions</p> <p><input type="checkbox"/> Feeling that you want to harm yourself or give up on life</p> <p><input type="checkbox"/> Other</p>	<p>2.3 您是否具有以下症状? <i>请勾选所有符合事实的选项</i></p> <p><input type="checkbox"/> 体重降低</p> <p><input type="checkbox"/> 咳嗽</p> <p><input type="checkbox"/> 咳血</p> <p><input type="checkbox"/> 盗汗</p> <p><input type="checkbox"/> 极度疲劳</p> <p><input type="checkbox"/> 呼吸问题</p> <p><input type="checkbox"/> 发烧</p> <p><input type="checkbox"/> 腹泻</p> <p><input type="checkbox"/> 皮肤不适或皮疹</p> <p><input type="checkbox"/> 尿血</p> <p><input type="checkbox"/> 便血</p> <p><input type="checkbox"/> 头痛</p> <p><input type="checkbox"/> 疼痛</p> <p><input type="checkbox"/> 情绪低落</p> <p><input type="checkbox"/> 焦虑</p> <p><input type="checkbox"/> 痛苦回忆或噩梦</p> <p><input type="checkbox"/> 睡眠障碍</p> <p><input type="checkbox"/> 感到您无法控制您的思维或动作</p> <p><input type="checkbox"/> 有自杀或自残的想法</p> <p><input type="checkbox"/> 其他</p>
<p>2.4 Please mark on the body image the area(s) where you are experiencing your current health problem(s)</p>	<p>2.4 请在此躯干图片中标出您认为出现健康问题的部位</p>









<p>2.5 Do you have any known health problems that are ongoing?</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes</p>	<p>2.5 您现在是否有已知的健康问题?</p> <p><input type="checkbox"/> 否</p> <p><input type="checkbox"/> 是</p>
<p>2.6 Do you have or have you ever had any of the following? Please tick all that apply</p> <p><input type="checkbox"/> Arthritis</p> <p><input type="checkbox"/> Asthma</p> <p><input type="checkbox"/> Blood disorder</p> <p style="padding-left: 20px;"><input type="checkbox"/> Sickle cell anaemia</p> <p style="padding-left: 20px;"><input type="checkbox"/> Thalassaemia</p> <p><input type="checkbox"/> Cancer</p> <p><input type="checkbox"/> Dental problems</p> <p><input type="checkbox"/> Diabetes</p> <p><input type="checkbox"/> Epilepsy</p> <p><input type="checkbox"/> Eye problems</p> <p><input type="checkbox"/> Heart problems</p> <p><input type="checkbox"/> Hepatitis B</p> <p><input type="checkbox"/> Hepatitis C</p> <p><input type="checkbox"/> HIV or AIDS</p> <p><input type="checkbox"/> High blood pressure</p>	<p>2.6 您是否有或曾经有过以下症状? 请勾选所有符合事实的选项</p> <p><input type="checkbox"/> 关节炎</p> <p><input type="checkbox"/> 哮喘</p> <p><input type="checkbox"/> 血液病</p> <p style="padding-left: 20px;"><input type="checkbox"/> 镰状细胞贫血</p> <p style="padding-left: 20px;"><input type="checkbox"/> 地中海贫血</p> <p><input type="checkbox"/> 癌症</p> <p><input type="checkbox"/> 牙科疾病</p> <p><input type="checkbox"/> 糖尿病</p> <p><input type="checkbox"/> 癫痫</p> <p><input type="checkbox"/> 眼疾</p> <p><input type="checkbox"/> 心脏疾病</p> <p><input type="checkbox"/> 乙肝</p> <p><input type="checkbox"/> 丙肝</p>

<input type="checkbox"/> Kidney problems <input type="checkbox"/> Liver problems <input type="checkbox"/> Long-term lung problem/breathing difficulties <input type="checkbox"/> Mental health problems <ul style="list-style-type: none"> <li><input type="checkbox"/> Low mood/depression</li> <li><input type="checkbox"/> Anxiety</li> <li><input type="checkbox"/> Post-traumatic stress disorder (PTSD)</li> <li><input type="checkbox"/> Previously self-harmed</li> <li><input type="checkbox"/> Attempted suicide</li> <li><input type="checkbox"/> Other</li> </ul> <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Skin disease <input type="checkbox"/> Stroke <input type="checkbox"/> Thyroid disease <input type="checkbox"/> Tuberculosis (TB) <input type="checkbox"/> Other	<input type="checkbox"/> 艾滋病 <input type="checkbox"/> 高血压 <input type="checkbox"/> 肾病 <input type="checkbox"/> 肝病 <input type="checkbox"/> 长期肺病/呼吸苦难 <input type="checkbox"/> 心理疾病 <ul style="list-style-type: none"> <li><input type="checkbox"/> 情绪低落/抑郁</li> <li><input type="checkbox"/> 焦虑</li> <li><input type="checkbox"/> 创伤后应激障碍</li> <li><input type="checkbox"/> 曾有自残行为</li> <li><input type="checkbox"/> 曾有自杀行为</li> <li><input type="checkbox"/> 其他</li> </ul> <input type="checkbox"/> 骨质疏松 <input type="checkbox"/> 皮肤病 <input type="checkbox"/> 中风 <input type="checkbox"/> 甲状腺疾病 <input type="checkbox"/> 肺结核 <input type="checkbox"/> 其他
2.7 Have you ever had any operations / surgery? <input type="checkbox"/> No <input type="checkbox"/> Yes	2.7 您是否曾经做过手术? <input type="checkbox"/> 否 <input type="checkbox"/> 是
2.8 If you have had an operation / surgery, how long ago was this? <input type="checkbox"/> In the last 12 months <input type="checkbox"/> 1 – 3 years ago <input type="checkbox"/> Over 3 years ago	2.8 如果您做过手术，该手术距今： <input type="checkbox"/> 低于 12 个月 <input type="checkbox"/> 1-3 年 <input type="checkbox"/> 3 年以上
2.9 Do you have any physical injuries from war, conflict or torture? <input type="checkbox"/> No <input type="checkbox"/> Yes	2.9 您是否在战争，冲突，或酷刑中受到过身体伤害? <input type="checkbox"/> 否 <input type="checkbox"/> 是
2.10 Do you have any mental health problems? These could be from war, conflict, torture or being forced to flee your country? <input type="checkbox"/> No <input type="checkbox"/> Yes	2.10 您是否有心理疾病？原因包括战争，冲突，酷刑，或被追逃离祖国。 <input type="checkbox"/> 否 <input type="checkbox"/> 是
2.11 Some medical problems can run in families. Has a member of your immediate family (father, mother, siblings, and grandparents) had or suffered from	2.11 有些疾病会在家族中遗传。您的直系亲属(父亲、母亲、兄弟姐妹和祖父母)是

<p>any of the following? Please tick all that apply</p> <p><input type="checkbox"/> Cancer  <input type="checkbox"/> Diabetes  <input type="checkbox"/> Depression/Mental health illness  <input type="checkbox"/> Heart attack  <input type="checkbox"/> High blood pressure  <input type="checkbox"/> Stroke  <input type="checkbox"/> Other</p>	<p>否有以下任何一种疾病? 请勾选所有符合事实的选项</p> <p><input type="checkbox"/> 癌症  <input type="checkbox"/> 糖尿病  <input type="checkbox"/> 抑郁/心理疾病  <input type="checkbox"/> 心脏病  <input type="checkbox"/> 高血压  <input type="checkbox"/> 中风  <input type="checkbox"/> 其他</p>								
<p>2.12 Are you on any prescribed medicines?  <input type="checkbox"/> No  <input type="checkbox"/> Yes –<i>please list your prescribed medicines and doses in the box below</i>  <b>Please bring any prescriptions or medications to your appointment</b></p> <table border="1" data-bbox="150 898 775 1267"> <thead> <tr> <th data-bbox="150 898 564 936">Name</th> <th data-bbox="564 898 775 936">Dose</th> </tr> </thead> <tbody> <tr> <td data-bbox="150 936 564 1267"></td> <td data-bbox="564 936 775 1267"></td> </tr> </tbody> </table>	Name	Dose			<p>2.12 您是否在服用处方药?  <input type="checkbox"/> 否  <input type="checkbox"/> 是——<i>请在下方框中列出您的处方药</i>  <b>请将任意处方药携带至预约地点</b></p> <table border="1" data-bbox="823 887 1453 1267"> <thead> <tr> <th data-bbox="823 887 1238 936">姓名</th> <th data-bbox="1238 887 1453 936">剂量</th> </tr> </thead> <tbody> <tr> <td data-bbox="823 936 1238 1267"></td> <td data-bbox="1238 936 1453 1267"></td> </tr> </tbody> </table>	姓名	剂量		
Name	Dose								
姓名	剂量								
<p>2.13 Are you worried about running out of any these medicines in the next few weeks?  <input type="checkbox"/> No  <input type="checkbox"/> Yes</p>	<p>2.13 您是否在担心未来几周内这些药品会被用完?  <input type="checkbox"/> 否  <input type="checkbox"/> 是</p>								
<p>2.14 Do you take any medicines that have not been prescribed by a health professional e.g medicines you have bought at a pharmacy/shop/on the internet or had delivered from overseas?  <input type="checkbox"/> No  <input type="checkbox"/> Yes –<i>please list medicines and doses in the box below</i>  <b>Please bring any medications to your appointment</b></p> <table border="1" data-bbox="150 1899 775 1933"> <thead> <tr> <th data-bbox="150 1899 564 1933">Name</th> <th data-bbox="564 1899 775 1933">Dose</th> </tr> </thead> <tbody> <tr> <td data-bbox="150 1933 564 1933"></td> <td data-bbox="564 1933 775 1933"></td> </tr> </tbody> </table>	Name	Dose			<p>2.14 您是否在服用一些没有经过专业医师开处方的药物? 例如, 您在药店, 商店, 网上购买, 或从国外运输至国内的药物。  <input type="checkbox"/> 否  <input type="checkbox"/> 是——<i>请在下方框中列出您的此类药物</i>  <b>请将任意此类药物携带至预约地点</b></p> <table border="1" data-bbox="823 1821 1453 1865"> <thead> <tr> <th data-bbox="823 1821 1238 1865">姓名</th> <th data-bbox="1238 1821 1453 1865">剂量</th> </tr> </thead> <tbody> <tr> <td data-bbox="823 1865 1238 1933"></td> <td data-bbox="1238 1865 1453 1933"></td> </tr> </tbody> </table>	姓名	剂量		
Name	Dose								
姓名	剂量								



2.15 Are you allergic to any medicines? <input type="checkbox"/> No <input type="checkbox"/> Yes		2.15 您是否对某些药物过敏? <input type="checkbox"/> 否 <input type="checkbox"/> 是	
2.16 Are you allergic to anything else? (e.g. food, insect stings, latex gloves)? <input type="checkbox"/> No <input type="checkbox"/> Yes		2.16 您是否对任何其他事物过敏? (例如: 食物, 虫类叮咬, 乳胶手套) <input type="checkbox"/> 否 <input type="checkbox"/> 是	
2.17 Do you have any physical disabilities or mobility difficulties? <input type="checkbox"/> No <input type="checkbox"/> Yes		2.17 您是否有残疾或行动障碍? <input type="checkbox"/> 否 <input type="checkbox"/> 是	
2.18 Do you have any sensory impairments? <i>Please tick all that apply</i> <input type="checkbox"/> No <input type="checkbox"/> Blindness <input type="checkbox"/> Partial sight loss <input type="checkbox"/> Full hearing loss <input type="checkbox"/> Partial hearing loss <input type="checkbox"/> Smell and/or taste problems		2.18 您是否有感官障碍? <i>请勾选所有符合事实的选项</i> <input type="checkbox"/> 否 <input type="checkbox"/> 失明 <input type="checkbox"/> 视力损伤 <input type="checkbox"/> 失聪 <input type="checkbox"/> 听力损伤 <input type="checkbox"/> 嗅觉和/或味觉疾病	
2.19 Do you have any learning difficulties? <input type="checkbox"/> No <input type="checkbox"/> Yes		2.19 您是否有学习障碍? <input type="checkbox"/> 否 <input type="checkbox"/> 是	
2.20 Is there any particular private matter you would like to discuss/raise at your next appointment with a healthcare professional? <input type="checkbox"/> No <input type="checkbox"/> Yes		2.20 在下次预约专业医师的时候, 您是否会讨论/提出一些您的特殊个人问题? <input type="checkbox"/> 否 <input type="checkbox"/> 是	

<p>Section three: Lifestyle questions</p>	<p>第三部分：生活方式</p>
<p>3.1 How often do you drink alcohol?</p> <p><input type="checkbox"/> Never</p> <p><input type="checkbox"/> Monthly or less</p> <p><input type="checkbox"/> 2-4 times per month</p> <p><input type="checkbox"/> 2-3 times per week</p> <p><input type="checkbox"/> 4 or more times per week</p> <p>There is <b>1 unit</b> of alcohol in:</p> <div style="text-align: center;">  <p><i>½ pint glass of beer</i></p> </div> <div style="text-align: center;">  <p><i>1 small glass of wine</i></p> </div> <div style="text-align: center;">  <p><i>1 single measure of spirits</i></p> </div>	<p>3.1 您饮酒的频率是？</p> <p><input type="checkbox"/> 从不</p> <p><input type="checkbox"/> 每月一次或更低</p> <p><input type="checkbox"/> 每月 2-4 次</p> <p><input type="checkbox"/> 每周 2-3 次</p> <p><input type="checkbox"/> 每周至少四次</p> <p>您摄入 <b>10 毫升</b> 纯酒精时的饮酒量为：</p> <div style="text-align: center;">  <p>半品脱杯啤酒</p> </div> <div style="text-align: center;">  <p>一小杯红酒</p> </div> <div style="text-align: center;">  <p>25 毫升烈酒</p> </div>
<p>a. How many units of alcohol do you drink in a typical day when you are drinking?</p> <p><input type="checkbox"/> 0-2</p> <p><input type="checkbox"/> 3-4</p> <p><input type="checkbox"/> 5-6</p> <p><input type="checkbox"/> 7-9</p> <p><input type="checkbox"/> 10 or more</p>	<p>a. 在普通场合饮酒时，您每次摄入的纯酒精量是多少？</p> <p><input type="checkbox"/> 0-20 毫升</p> <p><input type="checkbox"/> 30-40 毫升</p> <p><input type="checkbox"/> 50-60 毫升</p> <p><input type="checkbox"/> 70-90 毫升</p> <p><input type="checkbox"/> 100 毫升</p>
<p>b. How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?</p> <p><input type="checkbox"/> Never</p> <p><input type="checkbox"/> Less than monthly</p> <p><input type="checkbox"/> Monthly</p>	<p>b. 您单次摄入至少 60 毫升（女性）/80 毫升（男性）纯酒精的频率是？</p> <p><input type="checkbox"/> 从不</p> <p><input type="checkbox"/> 每月一次或更低</p>

<input type="checkbox"/> Weekly <input type="checkbox"/> Daily or almost daily	<input type="checkbox"/> 每月一次 <input type="checkbox"/> 每周一次 <input type="checkbox"/> 每天一次或接近每天一次
<p>c. Do you take any drugs that may be harmful to your health e.g. cannabis, cocaine, heroin?</p> <input type="checkbox"/> Never <input type="checkbox"/> I have quit taking drugs that might be harmful <input type="checkbox"/> Yes	<p>c. 您是否在服用对健康有损害的药物，如：大麻、可卡因、海洛因？</p> <input type="checkbox"/> 从不 <input type="checkbox"/> 我已经戒掉了所有对健康有损害的药物 <input type="checkbox"/> 是
<p>d. Do you smoke?</p> <input type="checkbox"/> Never <input type="checkbox"/> I have quit smoking <input type="checkbox"/> Yes <input type="checkbox"/> Cigarettes How many per day? _____ <p>How many years have you smoked for?  _____</p> <input type="checkbox"/> Tobacco <p>Would you like help to stop smoking?</p> <input type="checkbox"/> Yes <input type="checkbox"/> No	<p>d. 您吸烟吗？</p> <input type="checkbox"/> 从不 <input type="checkbox"/> 我已经戒烟 <input type="checkbox"/> 是 <input type="checkbox"/> 烟 您每天吸几根烟？ _____ <p>您的烟龄是 _____ 年</p> <input type="checkbox"/> 嚼烟 <p>您想帮助他人戒烟吗？</p> <input type="checkbox"/> 是 <input type="checkbox"/> 否
<p>e. Do you chew tobacco?</p> <input type="checkbox"/> Never <input type="checkbox"/> I have quit chewing tobacco <input type="checkbox"/> Yes	<p>e. 您吃嚼烟吗？</p> <input type="checkbox"/> 从不 <input type="checkbox"/> 我已经戒掉了嚼烟 <input type="checkbox"/> 是
<p>Section four: Vaccinations</p>	<p>第四部分：疫苗</p>
<p>4.1 Have you had all the childhood vaccinations offered in your country of origin?</p> <p><b><i>If you have a record of your vaccination history please bring this to your appointment.</i></b></p> <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> I don't know	<p>4.1 您是否在您儿时的所在国接种了所有儿童疫苗？</p> <p><b><i>如果您有疫苗接种记录，请将其带至预约地。</i></b></p> <input type="checkbox"/> 否 <input type="checkbox"/> 是 <input type="checkbox"/> 不知道

<p>4.2 Have you been vaccinated against Tuberculosis (TB)?</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> I don't know</p>	<p>4.2 您是否接种了肺结核疫苗？</p> <p><input type="checkbox"/> 否</p> <p><input type="checkbox"/> 是</p> <p><input type="checkbox"/> 不知道</p>
<p>4.3 Have you been vaccinated against COVID-19?</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes</p> <p style="padding-left: 20px;"><input type="checkbox"/> 1 dose</p> <p style="padding-left: 20px;"><input type="checkbox"/> 2 doses</p> <p style="padding-left: 20px;"><input type="checkbox"/> 3 doses</p> <p style="padding-left: 20px;"><input type="checkbox"/> More than 3 doses</p> <p><input type="checkbox"/> I don't know</p>	<p>4.3 您是否接种了新冠肺炎疫苗？</p> <p><input type="checkbox"/> 否</p> <p><input type="checkbox"/> 是</p> <p style="padding-left: 20px;"><input type="checkbox"/> 一针</p> <p style="padding-left: 20px;"><input type="checkbox"/> 两针</p> <p style="padding-left: 20px;"><input type="checkbox"/> 三针</p> <p style="padding-left: 20px;"><input type="checkbox"/> 三针以上</p> <p><input type="checkbox"/> 不知道</p>
<p>Section five: Questions for female patients only</p>	<p>第五部分：仅与女性相关的问题</p>
<p>5.1 Are you pregnant?</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> I might be pregnant</p> <p><input type="checkbox"/> Yes</p> <p>How many weeks pregnant are you? _____</p>	<p>5.1 您是否怀孕？</p> <p><input type="checkbox"/> 否</p> <p><input type="checkbox"/> 可能已怀孕</p> <p><input type="checkbox"/> 是</p> <p>您已怀孕几周？</p> <p>_____</p>
<p>5.2 Do you use contraception?</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes</p> <p>What method do you use?</p> <p><input type="checkbox"/> Barrier contraception e.g. condoms, gel</p> <p><input type="checkbox"/> Oral contraceptive pill</p> <p><input type="checkbox"/> Copper Coil/Intrauterine device (IUD)</p> <p><input type="checkbox"/> Hormonal coil/Intrauterine System (IUS) e.g. Mirena</p> <p><input type="checkbox"/> Contraceptive injection</p> <p><input type="checkbox"/> Contraceptive implant</p> <p><input type="checkbox"/> Other</p>	<p>5.2 您是否采取避孕措施？</p> <p><input type="checkbox"/> 否</p> <p><input type="checkbox"/> 是</p> <p>您采取了什么措施？</p> <p><input type="checkbox"/> 屏障避孕 例如：避孕套</p> <p><input type="checkbox"/> 口服避孕药</p> <p><input type="checkbox"/> 避孕环/子宫内避孕器</p> <p><input type="checkbox"/> 宫内节育器 例如：曼月乐</p> <p><input type="checkbox"/> 避孕注射</p> <p><input type="checkbox"/> 避孕植入</p> <p><input type="checkbox"/> 其他</p>
<p>5.3 Do you urgently need any contraception?</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes</p>	<p>5.3 您是否迫切需要避孕？</p> <p><input type="checkbox"/> 否</p> <p><input type="checkbox"/> 是</p>

<p>5.4 Have you ever had a cervical smear or a smear test? This is a test to check the health of your cervix and help prevent cervical cancer.</p> <p><input type="checkbox"/> No  <input type="checkbox"/> Yes  <input type="checkbox"/> I would like to be given more information</p>	<p>5.4 您是否接受过宫颈涂片试验? 这是一项检查宫颈健康和预防宫颈癌的试验。</p> <p><input type="checkbox"/> 否  <input type="checkbox"/> 是  <input type="checkbox"/> 我想了解更多</p>
<p>5.5 Have you had a hysterectomy (operation to remove your uterus and cervix)?</p> <p><input type="checkbox"/> No  <input type="checkbox"/> Yes</p>	<p>5.5 您做过子宫切除术(切除子宫和宫颈的手术)吗?</p> <p><input type="checkbox"/> 否  <input type="checkbox"/> 是</p>
<p>5.6 As a female patient is there any particular private matter you would like to discuss/raise at your next appointment with a healthcare professional?</p> <p><input type="checkbox"/> No  <input type="checkbox"/> Yes</p>	<p>5.6 作为一名女性患者, 在下次预约专业医师的时候, 您是否会讨论/提出一些您的特殊个人问题?</p> <p><input type="checkbox"/> 否  <input type="checkbox"/> 是</p>
<p>If there is something that you do not feel comfortable sharing in this form and you would like to discuss it with a doctor, please call your GP and book an appointment.</p>	<p>如果您感到不适且愿意在此表格中分享或与医生讨论, 请致电您的全科医生并预约。</p>