Hong Kong Surgery Personal Health Check Questionnaire 个人健康检查问卷

Name: ___________________ DOB ____________________

Please tick if you have any of these symptoms 如果您有任何这些症状，请打勾

- □ Low energy 低能量/ 没有精力
- □ Poor appetite 食欲不佳
- □ Poor sleep 睡眠不好
- □ Unintentional weight loss 没有理由体重减轻.
- □ Chest pain 胸痛
- □ Palpitations 心悸/心跳太快
- □ Dizziness 头晕
- □ Faintness 昏厥
- □ Cough 咳嗽
- □ Wheeze 喘息/ 哮鸣音
- □ Shortness of breath 呼吸短促
- □ Cough up blood 咳血
- □ Difficulty swallowing 吞咽困难
- □ Feeling of food sticking going down 吞咽时食物粘住感觉
- □ Abdomen pain 腹部疼痛
- □ Change in bowel habit 排便习惯改变
- □ Bleeding from the bowel 大便出血
- □ Difficulty starting or stopping urine stream 小便困难或漏尿
- □ Getting up to pass urine at night more than once 晚上起床排尿不止一次
- □ Headaches 头痛
- □ Eyesight problems 视力问题
- □ Hearing problems 听力问题
- □ Tingling fingers or toes 手指或脚趾刺痛
- □ Weakness in arms or legs 手臂或腿的疲软
- □ Neck, back pain, other joint pains 颈部，背部疼痛，关节疼痛
- □ Skin problems 皮肤问题
- □ Mood instability 情绪不稳定