

| <p>5. Had the patient previously referred by other physician? 病人是否經其他醫生轉介？</p> | <p><input type="checkbox"/> Yes (please provide name & address of the doctor) 是 (請提供醫生姓名及地址) <input type="checkbox"/> No 否</p> | | | | | | | | | | | | |
|--|---|----------------------|-------------------|--------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| <p>6. Details of the coronary artery disease 有關冠狀動脈疾病詳情</p> | <p>Coronary arteries involved 受影響的冠狀動脈 _____</p> <p>Percentage of occluded in respect of each involved artery 每條冠狀動脈閉塞程度的百分比 _____</p> <p>Was coronary angiography performed? 是否曾進行冠狀動脈造影術？ <input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否</p> <p>Was open-chest surgery performed? 是否需要透過開胸進行手術？ <input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否</p> <p>If yes, please provide details including date and type of surgery performed. 若是，請提供詳情，包括手術日期及類型。 _____</p> <p>If coronary bypass grafting, please state the numbers and sites of grafts inserted. 如為冠狀動脈旁路移植手術，請註明植入數目及位置 _____</p> <p>Types and details of other treatment rendered 其他所提供治療的種類及詳情 _____</p> <p>Did the patient have any treatments such as balloon angioplasty previously? <input type="checkbox"/> Yes 是 <input type="checkbox"/> No 否 病人以往是否曾接受其他如氣球血管擴張手術等治療？</p> <p>If yes, please provide details including reason, date and name of treatment received. 若是，請提供詳情，包括原因、治療日期及名稱。 _____</p> | | | | | | | | | | | | |
| <p>7. Details of all diagnostic tests (apart from above mentioned) performed and the result. 所有診斷檢驗（除上述已提及外）的詳情及結果。</p> <p><i>Please enclose copies of the diagnostic test and laboratory reports. 請附上診斷及化驗報告。</i></p> | <table border="1"> <thead> <tr> <th data-bbox="560 1189 805 1240">Date of Test 檢驗日期</th> <th data-bbox="805 1189 1300 1240">Test Item 檢驗項目</th> <th data-bbox="1300 1189 1522 1240">Result 結果</th> </tr> </thead> <tbody> <tr> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> <td>_____</td> </tr> </tbody> </table> | Date of Test 檢驗日期 | Test Item 檢驗項目 | Result 結果 | _____ | _____ | _____ | _____ | _____ | _____ | _____ | _____ | _____ |
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| _____ | _____ | _____ | | | | | | | | | | | |
| _____ | _____ | _____ | | | | | | | | | | | |
| _____ | _____ | _____ | | | | | | | | | | | |
| <p>8. Is there any patient's family history or other precipitating factors which would have increased the risk of this illness? 是次疾病是否因任何家族病史或其他因素促使增加患上此疾病的風險？</p> | <p><input type="checkbox"/> Yes (please provide details) 是 (請提供詳情) <input type="checkbox"/> No 否</p> | | | | | | | | | | | | |
| <p>9. Did the patient have any of the following habits - smoking, drinking or drugs taking? 病人是否有以下習慣 - 吸煙、飲酒或服用藥物？</p> | <p><input type="checkbox"/> Yes (please provide details) 是 (請提供詳情) <input type="checkbox"/> No 否</p> <p><input type="checkbox"/> Smoking 吸煙 <input type="checkbox"/> Drinking 飲酒 <input type="checkbox"/> Drug taking 服用藥物</p> <p>Duration 持續時間 _____ Consumption per day 每天用量 _____</p> | | | | | | | | | | | | |
| <p>10. Do you know whether the patient was suffering from any other major, chronic or congenital disease? 你是否知道病人曾患有任何其他嚴重、慢性或先天性疾病？</p> | <p><input type="checkbox"/> Yes (please provide details) 是 (請提供詳情) <input type="checkbox"/> No 否</p> <p>_____</p> <p>_____</p> | | | | | | | | | | | | |

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| <p>11. Please list details of all medical history (apart from what have mentioned above) that the patient had ever consulted you with. 請提供病人過去曾向你求診的所有醫療病歷詳情（除上述已提及外）。</p> | <p>Consultation date 求診日期</p> | <p>Complaints/Symptoms 主訴 / 病徵</p> | <p>Diagnosis 確診</p> | <p>Treatment given 所提供治療</p> |
| <p>12. Was there any usual physician of the patient other than you? 病人是否有其他慣常求診的醫生？</p> | <p><input type="checkbox"/> Yes (please provide name & address of the doctor) 是（請提供醫生姓名及地址） <input type="checkbox"/> No 否</p> | | | |
| <p>13. Have the biological parents or siblings of the patient been diagnosed prior to age 60 with any of the illnesses listed in the right side? 請問病人的親生父母或兄弟姐妹在六十歲之前有否患有右列之疾病？</p> | <p><input type="checkbox"/> Yes (please check appropriate and give details) 是（請選擇適當情況及提供詳情） <input type="checkbox"/> No 否</p> <p><input type="checkbox"/> Cancer 癌症</p> <p><input type="checkbox"/> Heart disease 心臟病</p> <p><input type="checkbox"/> Stroke 中風</p> <p><input type="checkbox"/> Diabetes 糖尿病</p> <p><input type="checkbox"/> Alzheimer's Disease 阿茲海默症</p> <p><input type="checkbox"/> Parkinson's Disease 帕金森病</p> <p><input type="checkbox"/> Polycystic Kidney Disease 多囊性腎病</p> <p><input type="checkbox"/> Other inherited disease or disorder 其他遺傳性疾病</p> <p>Please provide details 請提供詳情</p> | | | |
| <p>14. Any additional information you consider relevant to this claim. 其他與是次索償有關的資料。</p> | | | | |
| <p>Declaration 聲明</p> | | | | |
| <p>I hereby certify that I have personally examined and treated the patient in connection to the above condition and that the facts as given above present my opinion of his/her condition and all are true to the best of my knowledge and belief. I hereby declare that no information has been withheld by me at the request of the patient or his/her family.</p> <p>本人謹此聲明曾親自為病人檢查及作出診治，以上填報的各項資料乃本人基於病人的情況而提供意見，所有答案，就本人所知所信，均為事實全部並確實無訛。本人在此聲明，沒有任何病人或其家屬要求本人隱瞞任何資料。</p> | | | | |
| <p>_____ Name in block letters of Attending Physician / Specialist and Qualifications 主診 / 專科醫生姓名及資歷</p> | | | <p>_____ Address and Contact No. 地址及聯絡電話號碼</p> | |
| <p>_____ Signature of Attending Physician / Specialist (with chop) 主診 / 專科醫生署名（蓋印）</p> | | | <p>_____ Date (dd / mm / yyyy) 日期 (日 / 月 / 年)</p> | |