TNN	**THANH N. NGUYEN, M.D., INC.** 210 Hospital Circle, Suite G, Westminster, California 92683 Ph: (714) 890-4000 Fax: (714) 890-3699
	PATIENT INFORMATION

May we send information to your home address? ( ) Yes ( ) No

Patient Last Name: _____ Patient First Name: _____MI_____

Address: _____City:_____State: _____Zip:_____

Home Phone: _____Work Phone: _____ EXT_____

Cell Phone: _____e-mail: _____

Date of Birth: _____Gender: F_____M _____ Ethnic Origin: _____

Referred By: _____Marital Status (Circle One) S M D W

Spouse's Name: _____ Phone No: _____

***If patient is under 18 years old*:** **RESPONSIBLE PARTY**

Last Name: _____First Name:_____MI_____

Address_____City_____State_____Zip _____

Cell Phone _____ Home Phone: _____Work Phone: _____Ext._____

E-mail: _____

Date of Birth: _____Gender: F_____ M _____ Ethnic Origin: _____

For Workers' Comp. case only: **EMPLOYMENT INFORMATION**

Employer's Name: _____ Phone No: _____ Ext._____

Address: _____ City: _____State: _____ Zip: _____

Patient's Occupation: _____

If Applicable: **PRIMARY INSURANCE INFORMATION:**

Insurance Company: _____ ID# _____Group#_____

Policy Holder: _____ Birthdate: _____ SS# _____

Home Address: _____

Employer: _____ Employer Phone: _____

What procedure(s) are you interested in? _____
Have you ever seen another Doctor about this procedure? ( ) Yes ( ) No
If yes, what happened with this Doctor? _____

PERSON TO NOTIFY IN EMERGENCY:

Name_____ Relationship: _____ Phone No_____

I acknowledge that I am responsible for all the charges for services rendered to me.

PATIENT SIGNATURE_____DATE_____

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	PATIENT MEDICAL HISTORY page 1/2

Patient Name_____***Date***_____

Age_____ Height_____ Weight_____

General Health: Good_____ Fair_____ Poor_____

*If **NOT GOOD** please explain*_____

PAST MEDICAL HISTORY

*When was your last physical checkup?*_____

*List all **ALLERGIES** to medications.*_____

_____

*Please list all **PILLS OR MEDICATIONS** you are now taking.*_____

_____

*Do you take **ASPIRIN** regularly? Yes_____ No_____ If **YES**, how often?*_____

*Have you taken **STEROIDS OR CORTISONE** in the past year?*_____

*Do you **SMOKE**? Yes_____ No_____ How much?*_____

*Do you consume **ALCOHO**L? Yes _____ No ____ How much?* _____

*List all **PLASTIC SURGERY** you have had.*_____

_____

*List any other **SURGERY OR INJURIES** you have had.*_____

_____

*Have you had any **PROBLEMS OR COMPLICATIONS** after surgery? Yes_____ No_____*

*If **YES** please explain*_____

*Have you had any **UNPLANNED WEIGHT LOSS**? Yes___ No___ If **YES** how may pounds? _____*

*Are you under **MEDICAL TREATMENT** at this time? Yes_____ No_____*

*If **YES** please explain*_____

_____

*If you are having breast surgery, have you had a recent **MAMMOGRAM** ? Yes____ No____*
If yes, was it normal? Yes____ No____

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HAVE YOU HAD ANY ILLNESSES WITH THE FOLLOWING:

Yes	*No*	
___	___	*High blood pressure*
___	___	*Thyroid disease*
___	___	*Diabetes*
___	___	*Heart Attack*
___	___	*Bleeding Tendency*
___	___	*Seizures*
___	___	*Persistent Coughing*

Yes	*No*	
___	___	*Heart Problems*
___	___	*Arthritis*
___	___	*Blood Disorders*
___	___	*Ulcers*
___	___	*Nervous Disorders*
___	___	*Other*_____

*List Current **TREATMENT** for any of the above:*_____

_____

HAVE YOU EVER HAD ANY OF THE FOLLOWING:

Yes	*No*	
___	___	*A positive HIV test or AIDS test*
___	___	*Hepatitis or Yellow Jaundice*
___	___	*Bad reaction to general anesthetic*
___	___	*Allergic reaction to adhesive tape*
___	___	*Frequent boils or infections*
___	___	*Shortness of breath while walking*
___	___	*Significant emotional problems*
___	___	*Psychiatric treatment*
___	___	*Blood transfusion*
___	___	*Required large amounts of anesthesia for medical or dental procedures*
___	___	*Bad reaction of local anesthetic (novocaine, etc.)*
___	___	*Bruising easily*
___	___	*Large scarring or keloids*
___	___	*Slow or poor healer*

*Please explain all **YES** answers to the above"*_____

***FAMILY HISTORY** (Has any relative had):*

Yes	*No*	
___	___	*High blood pressure*
___	___	*Diabetes*
___	___	*Epilepsy*
___	___	*Kidney disease*
___	___	*Blood disease*
___	___	*Breast Cancer*

Yes	*No*	
___	___	*Cancer*
___	___	*Heart disease*
___	___	*Lung disease*
___	___	*Asthma*
___	___	*Mental disease*

*Patient Signature*_____ *Date* _____

*Home Phone*_____ *Phone where you will be staying*_____

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At the time of consultation, and pre-operatively, Dr. Thanh N. Nguyen, will perform a limited, problem-focused history and physical exam on you. It is not a complete physical check-up.

You will still need to see your regular physician for a complete check-up, or management of your existing medical problems.

_____	_____	_____
Print Patient's name	Patient Signature	Date