

**ENT & SINUS CENTER, PC**  
**Henry H Nguyen, MD**

Date: \_\_\_\_\_

Family doctor: \_\_\_\_\_

Patient Name: \_\_\_\_\_  
LAST FIRST MIDDLE

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_  
MM DD YYYY

Job Title: \_\_\_\_\_

Height: \_\_\_\_\_

Weight: \_\_\_\_\_

Employer: \_\_\_\_\_

Marital Status:  S  M  W  D

Sex: M or F

<b>Allergies: List your allergies to medications</b> _____ _____ _____	<b>Other Allergic Reactions</b> <b>(Mold, dust, pollen, food, Over the counter medications etc.)</b> _____ _____
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**PLEASE LIST YOUR CURRENT MEDICATIONS.** Please include herbal supplements, vitamins, Tylenol, Advil/Motrin and over-the-counter medications. **IT IS VERY IMPORTANT THAT YOU LET YOUR DOCTOR KNOW IF ANY OF THE FOLLOWING SUPPLEMENTS ARE USED: Echinacea, Ephedra, Metabolife or similar product, Garlic, Gingko, Ginseng, Kava, St. John's Wart, Valerian.**

1.		6.	
2.		7.	
3.		8.	
4.		9.	
5.		10.	

**PLEASE DESCRIBE YOUR PRESENT SYMPTOMS:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**FAMILY HISTORY** (Please describe your relationship to affected family members)

\_\_\_\_\_ Heart Disease      \_\_\_\_\_ Diabetes      \_\_\_\_\_ Asthma  
 \_\_\_\_\_ Stroke      \_\_\_\_\_ Thyroid      \_\_\_\_\_ High Blood Pressure  
 \_\_\_\_\_ Cancer      \_\_\_\_\_ Bleeding Problems      \_\_\_\_\_ Problems with Anesthesia  
 \_\_\_\_\_ Hearing Loss      \_\_\_\_\_ Allergies      \_\_\_\_\_ Others

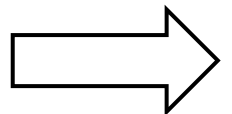
**SOCIAL HISTORY**

Please answer honestly. This information is needed to assure the best possible treatment. All information is CONFIDENTIAL. Please check all that apply:

- Alcohol \_\_\_\_\_ Type/Amount per week
- Cigarettes \_\_\_\_\_ Packs per day \_\_\_\_\_ Years smoking \_\_\_\_\_ Year if you quit smoking already
- Coffee/Tea \_\_\_\_\_ Cups per day
- Soda \_\_\_\_\_ Type/Amount per day

Have you ever been treated for alcohol or substance abuse? \_\_\_\_\_No \_\_\_\_\_Yes

**Female only:** Do you have any reasons to believe that you may be pregnant? \_\_\_\_\_No \_\_\_\_\_Yes



**REVIEW OF SYSTEMS** (Please check yes or no to each of these conditions)

<b>EARS</b>	<b>YES</b>	<b>NO</b>	<b>THROAT</b>	<b>YES</b>	<b>NO</b>	<b>GASTROINTESTINAL</b>	<b>YES</b>	<b>NO</b>
Hearing Loss			Soreness			Acid Reflux		
Ringing in Ears			Difficulty Swallowing			Stomach Ulcer		
Dizziness			Pain on Swallowing			Diarrhea		
Pain			"Lump" feeling			Hepatitis		
Discharge			Tonsillitis			Blood in Stool		
Hearing Aid			Hoarseness			Constipation		
Exposure to loud noise			Bad Breath			Colitis		
Surgery			Bad Taste			Indigestion/Heartburn		
<b>NOSE</b>	<b>YES</b>	<b>NO</b>	Throat Clearing			<b>GENERAL</b>	<b>YES</b>	<b>NO</b>
Difficulty breathing			Lump			Diabetes		
Stuffiness			Recent Dental work			Back pain		
Change in smell			Surgery			Arthritis		
Post Nasal Drip			<b>RESPIRATORY</b>	<b>YES</b>	<b>NO</b>	Fainting Spells		
Nosebleeds			Asthma/Emphysema			HIV		
Injuries			Cough			Kidney Disease		
Nasal Sprays			Coughing Blood			Difficulty Urinating		
Snoring			Lung Disease			Kidney Stones		
Surgery			Tuberculosis			Vaginitis		
<b>NECK</b>	<b>YES</b>	<b>NO</b>	Shortness of Breath			Depression		
Lumps			Pneumonia			Anxiety		
Thyroid Nodules			<b>CARDIOVASCULAR</b>	<b>YES</b>	<b>NO</b>	Bipolar Disorder		
Thyroid Disease			Chest Pain			Headache		
Pain			Heart Disease			Paralysis		
Injuries			High Blood Pressure			Weight Loss		
Swollen Glands			Irregular Heart Beat			Lyme Disease		
Surgery			Stroke			Psoriasis		
<b>EYES</b>	<b>YES</b>	<b>NO</b>	Heart Failure			Eczema		
Glaucoma			Rheumatic Fever			Rash		
Double Vision			Anemia			Cancer		
Loss of Vision			Easy Bruising			Rash		

**HOSPITALIZATIONS (PAST HISTORY)**

	DESCRIPTIONS	YEAR
<b>Major Illness</b>	_____	_____
	_____	_____
	_____	_____
	_____	_____
<b>Surgeries</b>	_____	_____
	_____	_____
	_____	_____
	_____	_____

Has any member of your family ever been seen by this practice? \_\_\_\_\_  
 I certify that information is true and correct to the best of my knowledge.

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

<b>OFFICE USE ONLY</b>  Review Date/ Dr. 's Signature
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