

1188 Bishop St. #1102
Honolulu, HI 96813

Lisa Nguyen MD LLC

3660 Waiialae Ave. #208
Honolulu, HI 96816

80 Pauahi St. #104
Hilo, HI 96720

Tel: (850)888-8598

Fax: (888)354-2480

NEW PATIENT REGISTRATION FORM

Patient Information:

Date: _____ Name: _____

Date of Birth: _____ SSN: _____ Gender: _____

Address: _____ City: _____ State: _____ ZIP: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Email Address: _____

Occupation: _____ Employer: _____

Employer Address: _____ City: _____ State: _____ ZIP: _____

Emergency Contact: _____ Relationship: _____

Address: _____ Phone: _____

IF Patient has a Guardian or is a Minor:

Guardian/Caregiver Name: _____ Relationship: _____

Date of Birth: _____ SSN: _____ Gender: _____

Address: _____ City: _____ State: _____ ZIP: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Email Address: _____

Insurance Information:

Primary Insurance: _____ Subscriber ID: _____

Subscriber Name: _____ Relationship to Patient: _____

Subscriber Date of Birth: _____ Subscriber SSN: _____

Address: _____ Phone: _____ Gender: _____

Secondary Insurance: _____ Subscriber ID: _____

Subscriber Name: _____ Relationship to Patient: _____

Subscriber Date of Birth: _____ Subscriber SSN: _____

Address: _____ Phone: _____ Gender: _____

Primary Care Physician/Referring Physician:

Name of Provider: _____ Date of last visit: _____

Phone: _____ FAX: _____ Email: _____

Address: _____ City: _____ State: _____ ZIP: _____

Medical History:

Medicine Allergies: _____ What was the reaction? (eg hives): _____

Other allergies (eg food): _____ What was the reaction? (eg hives): _____

Medical Problems: _____

Past Surgeries (what procedure, when): _____

Current Medication(s): _____

Psychiatric History:

Past psychiatric medication(s), how they worked, duration of treatment: _____

Psychiatric hospitalization(s), reason for admission, date, duration of stay: _____

Family History:

Any blood relatives with psychiatric conditions, addition problems, other medical conditions (eg cancers, thyroid imbalance etc.): _____

SYSTEMS REVIEW

Please **circle** any conditions that are **presently** causing you a problem and **underline** those that have caused you problems in the **past**.

<p>GENERAL SYMPTOMS</p> <p>Fever Sweats Fainting Sleep disturbance Fatigue Nervousness Weight loss Weight gain</p>	<p>RESPIRATORY</p> <p>Chronic cough Spitting up phlegm Spitting up blood Chest pain Wheezing Difficulty breathing Asthma</p>	<p>GENITOURINARY</p> <p>Frequent urination Painful urination Blood in urine Pus in urine Kidney infection Prostate trouble Uncontrollable urine flow</p>
<p>NEUROLOGICAL</p> <p>Visual disturbances Dizziness Fainting Convulsions Headache Numbness Neuralgia (nerve pain) Poor coordination Weakness</p>	<p>CARDIOVASCULAR</p> <p>Rapid beating heart Slow beating heart High blood pressure Low blood pressure Pain over heart Hardening of arteries Swollen ankles Poor circulation Palpitations Cold hands or feet Varicose veins</p>	<p>GASTROINTESTINAL</p> <p>Poor appetite Difficult digestion Heartburn Ulcers Nausea Vomiting Constipation Diarrhea Blood in stool Gallbladder/jaundice Colitis</p>
<p>EENT</p> <p>Eye pain Double vision Ringing in ears Deafness Nosebleeds Trouble swallowing Hoarseness Sinus infection Nasal drainage Enlarged glands</p>	<p>MUSCLE & JOINT</p> <p>Neck pain Low back pain Arm pain Shoulder pain Leg pain Knee pain Foot pain Pain/numbness down arms or legs Pain between shoulders Swollen joints Spinal curvature Arthritis Fractures</p>	<p>FOR WOMEN ONLY</p> <p>Painful menstruation Hot flashes Irregular cycle Cramps or back pain Vaginal discharge Nipple discharge Lumps in breast Menopausal symptoms Birth control pills Miscarriages Complications with pregnancy Pregnant? Y/N Week? Other:</p>