BRENT MOELLEKEN, M.D.

Patient Information

TODAY'S DATE:_____

LAST NAME:	FIRST NAME:	MI:
STREET ADDRESS:	APT # /CITY, STATE:	ZIP CODE:
SEX: DOB: / /	SSN: - -	DRIVER'S LICENSE #:_____
EMAIL ADDRESS:	HOME TEL #:	CELL #:

Drug Allergies? Please circle your answer : ***YES*** ***NO***

If yes, please list the medications: _____

EMPLOYMENT INFORMATION

EMPLOYER'S NAME:	TELEPHONE #:	
STREET ADDRESS:	CITY, STATE:	ZIP CODE:

INSURANCE INFORMATION

INSURANCE COMPANY (PRIMARY):		
INSURANCE COMPANY ADDRESS:	CITY,STATE:	ZIP CODE:
GROUP/POLICY #:	INSURED NAME (IF NOT PATIENT):	
RELATIONSHIP TO PATIENT:		

EMERGENCY CONTACT

EMERGENCY CONTACT:	RELATIONSHIP TO YOU:	
STREET ADDRESS:	APT#/CITY, STATE:	ZIP CODE:
TELEPHONE #:		

TO OUR PATIENTS: ALL PATIENTS, INCLUDING THOSE WITH INSURANCE, ARE RESPONSIBLE FOR PAYMENT OF THE DOCTOR'S FEES. WE WILL BE GLAD TO ASSIST YOU IN OBTAINING PAYMENT FROM YOUR INSURANCE COMPANY.

IT IS CUSTOMARY FOR ALL PROFESSIONAL SERVICES TO BE PAID FOR WHEN RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE WITH THE OFFICE MANAGER.

SIGNATURE OF REPSONSIBLE PARTY: _____

120 South Spalding Dr., Suite 110
Beverly Hills, CA 90212
(P) 310.273.1001 (F) 310.205.4881
www.drbrent.com

601 East Arrellaga St., Suite 103
Santa Barbara, CA 93103
(P) 805.979.2535 (F) 310.205.4881
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Health History

BRENT MOELLEKEN, M.D.

NAME:_____ **DATE OF BIRTH:**_____

HAVE YOU EVER HAD ANY OF THE FOLLOWING CONDITIONS:

Aids or HIV +	No	Yes	Hemorrhoids	No	Yes
Anemia	No	Yes	Hepatitis	No	Yes
Arthritis	No	Yes	Hernia	No	Yes
Asthma	No	Yes	High Blood Pressure	No	Yes
Autoimmune Disease	No	Yes	Kidney Disease	No	Yes
Bladder Infection	No	Yes	Low Blood Pressure	No	Yes
Bleeding Tendency	No	Yes	Measles	No	Yes
Blood or Plasma Transfusions	No	Yes	Migraine Headaches	No	Yes
Bronchitis	No	Yes	Pneumonia	No	Yes
Cancer	No	Yes	Stroke	No	Yes
Diabetes	No	Yes	Thyroid Disease	No	Yes
Diphtheria	No	Yes	Tuberculosis	No	Yes
Epilepsy	No	Yes	Ulcer	No	Yes
Glaucoma	No	Yes	Whooping Cough	No	Yes

CARDIOVASCULAR

Heart Disease	No	Yes
Chest Pain	No	Yes
Shortness of breath	No	Yes
Swelling of feet/ankles/hands	No	Yes
Chronic or frequent cough	No	Yes

EARS/ NOSE/ THROAT

Hearing loss/ringing	No	Yes
Earaches/drainage	No	Yes
Sinus problem or rhinitis	No	Yes
Nose bleeds	No	Yes
Mouth sores	No	Yes
Sore throat or voice change	No	Yes
Swollen glands in neck	No	Yes

ENDOCRINE

Glandular or hormone problem	No	Yes
Excessive thirst or urination	No	Yes
Heat/Cold Intolerance	No	Yes
Dry Skin	No	Yes

EYES

Eye Disease or Injury	No	Yes
Wear glasses/contact lenses	No	Yes
Blurred or double vision	No	Yes

GASTROINTESTINAL

Loss of appetite	No	Yes
Change in bowel movements	No	Yes
Nausea or vomiting	No	Yes
Frequent diarrhea	No	Yes
Constipation	No	Yes
Blood in stool	No	Yes
Abdominal pain	No	Yes

GENITOURINARY

Frequent urination	No	Yes
Burning or painful urination	No	Yes
Blood in urine	No	Yes
Incontinence or dribbling	No	Yes
Kidney stones	No	Yes
Male-testicle pain	No	Yes

HEMATOLOGIC/ LYMPHATIC

Bleeding or bruising tendency	No	Yes
Anemia	No	Yes
Phlebitis	No	Yes
Past transfusion	No	Yes

IMMUNOLOGIC/ ALLERGIC

History of skin reaction or adverse reaction to:

Penicillin or other antibiotics	No	Yes
Morphine/Demerol/Novocain	No	Yes
Aspirin or other pain remedies	No	Yes

Other drug medication:_____

_____

_____

Food allergies: _____

Other allergies: _____

INTEGUMENTARY (SKIN/BREAST)

Rash or itching	No	Yes
Change in skin color	No	Yes
Change in hair or nails	No	Yes
Varicose veins	No	Yes
Breast pain/lump	No	Yes
Breast discharge	No	Yes

MUSCULOSKELETAL

Joint pain	No	Yes
Joint stiffness or swelling	No	Yes
Weakness of muscles/joints	No	Yes
Muscle pain or cramps	No	Yes

NEUROLOGICAL

Headaches/ Dizziness	No	Yes
Numbness of tingling sensation	No	Yes
Tremors	No	Yes
Paralysis	No	Yes
Head injuries	No	Yes

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Health History 2

NAME:_____ **DATE OF BIRTH:**_____

PATIENT SOCIAL HISTORY (Circle One)

Marital Status: Single Married Divorced Widowed

Use of Alcohol: Never Rarely Moderate Daily Type_____

Use of Tobacco: Never Previously quit Current packs/day

Use of Drugs: Never Type/frequency _____

PSYCHIATRIC

Memory loss or confusion	No	Yes
Nervousness	No	Yes
Depression	No	Yes
Insomnia	No	Yes

Have you or a family member had malignant hyperthermia?

_____

Please list any other medical history doctor should be aware of:

_____

_____

Please list any hospitalizations (e.g., accidents, etc.):

_____

_____

FAMILY HISTORY: Please give the age of the living, or if deceased, cause of death an age of deceased.

Father: _____ Mother: _____

Siblings: _____ Children: _____

MEDICATIONS: Please list medications you currently take, including appetite suppressants, vitamins, herbal supplements or any homeopathic medication:

_____

_____

SURGICAL HISTORY: Please list all previous surgeries/ operations, including cosmetic:

_____ DATE: _____

_____ DATE: _____

_____ DATE: _____

_____ DATE: _____

FAMILY PHYSICIAN:_____ **DATE OF LAST CHECK UP:**_____

HEIGHT:_____

WEIGHT:_____

MAX WEIGHT:_____

CHILDREN:

AGE:_____

NATURAL BIRTH OR CESAREAN:_____

MAX WEIGHT DURING PREGNANCY:_____

NOTE: IF YOU ARE SCHEDULED FOR SURGERY, PLEASE BE ADVISED THAT YOU CANNOT TAKE PRODUCTS CONTAINING ASPIRIN FOR A PERIOD OF TWO WEEKS PRIOR TO YOUR SURGERY. EVIDENCE SUGGESTS THAT EVEN SMALL AMOUNTS OF ASPRIN OR OTHER ANTI-INFLAMMATORY PRODUCTS CAN CREATE BLEEDING PROBLEMS ON THE OTHERWISE HEALTHY ADULT. ACETAMINOPHEN, SUCH AS TYLENOL, MAY BE USED AS A SUBSTITUTE FOR ASPRIN.

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HIPPA Patient Acknowledgment

DATE: _____

The undersigned acknowledges receipt of a copy of the current effective *Notice of Privacy Practices* for this business. A copy of this signed, dated Acknowledgment shall be as effective as the original. My signature will also serve as a documents release should I request treatment records, photographs be sent to other attending physicians in the future.

PRINT NAME: _____

SIGNATURE: _____

LEGAL REPRENTATIVE _____

DESCRIPTION OF AUTHORITY _____

Please list any other parties who can have access to your healthcare information:
(Step parents, grandparents and any care takers who can access this patient's records)

NAME: _____ RELATIONSHIP: _____

NAME: _____ RELATIONSHIP: _____

I authorize contact from this office to confirm my healthcare appointments, treatment, billing and information about my health via:

- ☐ Cell phone
- ☐ Home phone
- ☐ Work phone
- ☐ Email
- ☐ U.S. Mail
- ☐ Any of the above

I approve being contacted about special services, events or new healthcare information via:

- ☐ Cell phone
- ☐ Home phone
- ☐ Work phone
- ☐ Email
- ☐ U.S. Mail
- ☐ Any of the above

Print Name: _____ **Signature:** _____

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