



BRENTVIEW MEDICAL

11611 San Vicente Blvd.
Los Angeles, CA 90049

Medical History Questionnaire – Confidential Information

PATIENT INFORMATION

Last Name: _____ First Name: _____ M.I.: _____

Today's Date: _____ Birth Date: _____ Age: _____ Male Female

Home Phone: (____) _____ Cell Phone: (____) _____ Work Phone (____) _____

Address: _____

City: _____ State: _____ Zip: _____

Social Security #: _____ Driver's License #: _____ State: _____

Emergency Contact Name: _____ Relationship: _____ Phone: (____) _____

Employer: _____

Work Address: _____

City: _____ State: _____ Zip: _____

Occupation: _____ E-mail: _____

Is it OK to leave test results/messages on your answering machine? Yes No Is it OK to contact you at work? Yes No

Marital Status: Single Married Separated Divorced Widowed

Ethnicity: Caucasian African American Hispanic Asian Middle Easter Other: _____

How did you learn about Brentview Medical? _____

SPOUSE OR RESPONSIBLE PARTY INFORMATION

Spouse/Responsible Party: _____

Home Phone (____) _____ E-mail: _____

Address: _____

City: _____ State: _____ Zip: _____

Social Security #: _____ Driver's License #: _____ State: _____

Cell Phone: (____) _____ Business Phone: (____) _____ Birth Date: _____

INSURANCE INFORMATION

Do you have medical insurance: Yes No. If yes, provide us with your card and valid photo I.D. for a photocopy to be made.

Name of Insured: _____

Relationship to insured: Self Spouse Child Other: _____

Primary Insurance: _____ Group #: _____ Member I.D. #: _____

Secondary Insurance: _____ Group #: _____ Member I.D. #: _____

RELEASE ASSIGNMENT

I hereby authorize Brentview Medical or designee to disclose when requested by the above named / attached medical insurance carrier or its representative or any other insurance entity any and all information with respect to any illness, injury, medical history, or treatment and copies of all medical records. I hereby authorize payments and/or any medical benefits to Brentview Medical or designee for professional services rendered to me. I understand that I am financially responsible for all charges for all services provided. Although I have requested the physician to bill my medical insurance carrier on my behalf as a courtesy to me, I clearly understand that it is my responsibility to make sure that the bill is paid in a reasonable time. In the event that the insurance company denies benefits or makes a partial payment, I further agree to make arrangements for prompt payment of the balance due. A photo static copy of this authorization shall be considered as effective and valid as the original.

Signed: _____ Date: _____

Name: _____

Date: _____

MEDICAL INFORMATION

Reason for visit _____

PAST & PRESENT MEDICAL HISTORY: Please list all current medical problems (ie. High Blood Pressure, Diabetes, etc...)

Medical Problem	Year Diagnosed
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PAST SURGICAL HISTORY

Surgery	Date
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MEDICATIONS

Medication name	Dose	How often
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ALLERGIES

	YES	NO
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Are you sensitive/allergic to any medications? YES NO

If yes, please list: _____

If yes, what happens? _____

FAMILY HISTORY

	Living?	Age/Age of Death	Medical Problems/Cause of Death
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Mother Yes No _____

Father Yes No _____

Brother(s) Yes No _____

Sister(s) Yes No _____

Children Yes No _____

Do you have a family history (parents, siblings, children) of:

	YES	NO
Heart attack	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>

If yes, which family member _____

SOCIAL HISTORY

Do you drink alcohol? YES NO

If yes, how often? _____

Have you ever smoked? YES NO

Do you smoke now? YES NO

If yes, how many packs per day? _____

Have you ever used recreational drugs? YES NO (Leave blank

Do you use recreational drugs now? YES NO if desired)

If yes, how often? _____

If yes, what type of drugs? _____

FEMALE HISTORY

Number of pregnancies you have had: _____

Number of abortions/miscarriages you have had: _____

Number of children you have: _____

Ages of your children: _____

Age at first menstruation: _____

How many days apart are your periods? _____

How long do your periods last? _____

Are you currently taking birth control pills? _____

Age at menopause: _____

PREVENTIVE MEDICINE: When was your last:

Colonoscopy _____

Mammogram _____

Pap smear _____

Breast exam _____

Prostate exam/PSA _____

Self testicular exam _____

Flu shot _____

Pneumonia vaccine _____

Cardiac stress test _____

MISCELLANEOUS

Birthplace: _____

How long you have lived in this area: _____

Have you ever had a job/hobby involving plastics, chemicals, sandblasting or industrial dusts? YES NO

If yes, please describe: _____

Have you traveled to any second or third world countries in the last 2 years? YES NO

Would you like to be tested for sexually transmitted diseases? YES NO

MEDICAL INFORMATION (continued)

REVIEW OF SYSTEMS

Please check all that apply to you currently:

	YES	NO		YES	NO
GENERAL			Abnormal stool	<input type="checkbox"/>	<input type="checkbox"/>
Fever	<input type="checkbox"/>	<input type="checkbox"/>	Blood in stool	<input type="checkbox"/>	<input type="checkbox"/>
Chills	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Nausea	<input type="checkbox"/>	<input type="checkbox"/>	Yellow skin	<input type="checkbox"/>	<input type="checkbox"/>
Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>
Unexplained weight loss	<input type="checkbox"/>	<input type="checkbox"/>	URINARY		
SKIN			Burning with urination	<input type="checkbox"/>	<input type="checkbox"/>
Rashes	<input type="checkbox"/>	<input type="checkbox"/>	Increased frequency of urination	<input type="checkbox"/>	<input type="checkbox"/>
Lumps	<input type="checkbox"/>	<input type="checkbox"/>	Urinary incontinence	<input type="checkbox"/>	<input type="checkbox"/>
Color change	<input type="checkbox"/>	<input type="checkbox"/>	Blood in Urine	<input type="checkbox"/>	<input type="checkbox"/>
Dry skin	<input type="checkbox"/>	<input type="checkbox"/>	Loss of urine with cough/laugh	<input type="checkbox"/>	<input type="checkbox"/>
Hair loss	<input type="checkbox"/>	<input type="checkbox"/>	Kidney stone	<input type="checkbox"/>	<input type="checkbox"/>
Irregular moles	<input type="checkbox"/>	<input type="checkbox"/>	Urination at night	<input type="checkbox"/>	<input type="checkbox"/>
HEAD			How many times per night? _____		
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	MALE REPRODUCTIVE		
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Erectile dysfunction	<input type="checkbox"/>	<input type="checkbox"/>
EYES			Decreased libido	<input type="checkbox"/>	<input type="checkbox"/>
Blurry vision / Double vision	<input type="checkbox"/>	<input type="checkbox"/>	Genital sores	<input type="checkbox"/>	<input type="checkbox"/>
Eye pain	<input type="checkbox"/>	<input type="checkbox"/>	Testicular pain	<input type="checkbox"/>	<input type="checkbox"/>
EARS			Testicular lumps	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty hearing	<input type="checkbox"/>	<input type="checkbox"/>	FEMALE REPRODUCTIVE		
Ear ringing	<input type="checkbox"/>	<input type="checkbox"/>	Genital sores	<input type="checkbox"/>	<input type="checkbox"/>
Ear pain	<input type="checkbox"/>	<input type="checkbox"/>	Vaginal itching	<input type="checkbox"/>	<input type="checkbox"/>
NOSE			Vaginal discharge	<input type="checkbox"/>	<input type="checkbox"/>
Runny nose / Stuffy nose	<input type="checkbox"/>	<input type="checkbox"/>	Vaginal pain	<input type="checkbox"/>	<input type="checkbox"/>
Nose bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Vaginal bleeding	<input type="checkbox"/>	<input type="checkbox"/>
THROAT			Excessive body/facial hair	<input type="checkbox"/>	<input type="checkbox"/>
Sore throat	<input type="checkbox"/>	<input type="checkbox"/>	Breastfeeding	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty swallowing	<input type="checkbox"/>	<input type="checkbox"/>	Pregnant	<input type="checkbox"/>	<input type="checkbox"/>
BREASTS			RHEUMATOLOGIC		
Breast lumps	<input type="checkbox"/>	<input type="checkbox"/>	Joint pain	<input type="checkbox"/>	<input type="checkbox"/>
Breast tenderness	<input type="checkbox"/>	<input type="checkbox"/>	Joint stiffness	<input type="checkbox"/>	<input type="checkbox"/>
Nipple discharge	<input type="checkbox"/>	<input type="checkbox"/>	Weakness	<input type="checkbox"/>	<input type="checkbox"/>
LUNGS			Dry mouth	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	METABOLIC		
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	Excessive hunger	<input type="checkbox"/>	<input type="checkbox"/>
Cough	<input type="checkbox"/>	<input type="checkbox"/>	Excessive thirst	<input type="checkbox"/>	<input type="checkbox"/>
Sputum production	<input type="checkbox"/>	<input type="checkbox"/>	Excessive heat intolerance	<input type="checkbox"/>	<input type="checkbox"/>
What color _____			Excessive cold intolerance	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Tremor	<input type="checkbox"/>	<input type="checkbox"/>
Night sweats	<input type="checkbox"/>	<input type="checkbox"/>	Change in skin pigmentation	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	HEMATOLOGIC		
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding problems	<input type="checkbox"/>	<input type="checkbox"/>
CARDIOVASCULAR			Easy bruising	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	Transfusion reactions	<input type="checkbox"/>	<input type="checkbox"/>
Palpitations	<input type="checkbox"/>	<input type="checkbox"/>	NEUROLOGIC		
Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	Convulsions	<input type="checkbox"/>	<input type="checkbox"/>
Heart attack	<input type="checkbox"/>	<input type="checkbox"/>	Paralysis	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain with walking	<input type="checkbox"/>	<input type="checkbox"/>	Involuntary movements	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath with lying down	<input type="checkbox"/>	<input type="checkbox"/>	Numbness	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath with exercise	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Leg swelling	<input type="checkbox"/>	<input type="checkbox"/>	Memory difficulty	<input type="checkbox"/>	<input type="checkbox"/>
GASTROINTESTINAL			Speech difficulty	<input type="checkbox"/>	<input type="checkbox"/>
Abdominal pain	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	<input type="checkbox"/>
Heartburn	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Is there anything not listed on this form that you would like to tell us?		
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	_____		



BRENTVIEW MEDICAL

Notice of Privacy Practices

To our patients. This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.

We realize that these laws are complicated, but we must provide you with the following important information:

Use and disclosure of your health information in certain special circumstances

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of U.S or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials, if you are an inmate or under the custody of a law enforcement official.
8. For Workers Compensation and similar programs.

Your rights regarding your health information

1. Communications. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records, but not including psychotherapy notes. You must submit your request in writing to Maurice Darvish, M.D. 11611 San Vicente Blvd., Los Angeles, CA, 90049 or contact number 310 820 0013.
4. You may ask us to amend your health information if you believe it is correct or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to Maurice Darvish, M.D. 11611 San Vicente Blvd., Los Angeles, CA, 90049 contact number 310 820 0013. You must provide us with a reason that supports your request for amendment.
5. Right to a copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practice. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this notice, contact our front desk receptionist.
6. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the department of Health and Human Services. To file a complaint with our practice, contact Maurice Darvish, M.D. 11611 San Vicente Blvd., Los Angeles, CA, 90049 contact number 310 820 0013. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
7. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our health information privacy policies, please contact Maurice Darvish, M.D. 11611 San Vicente Blvd., Los Angeles, CA, 90049 contact number 310 820 0013.

I hereby acknowledge that I have been presented with a copy of Brentview Medical's Notice of Privacy Practices.

Signature _____

Date _____

Printed Name _____