,

WESLEY A. KING, M.D.
120 S. SPALDING DR. BEVERLY HILLS, CA. 90212
TEL: (310) 385-1918 FAX: (310) 385-9007

NAME:_____AGE:_____ M_____F_____

DATE OF BIRTH: _____ HANDEDNESS: RIGHT _____ LEFT _____

HOME ADDRESS: _____CITY:_____ZIP CODE: _____

HOME: (_____) _____ BUSINESS: (___) _____

CELL: (_____) _____ FAX: (_____) _____

S.S. #_____DRIVER'S LICENSE:_____

MARRIED: _____ SINGLE: _____ WIDOWED: _____ DIVORCED: _____ SEPARATED: _____

OCCUPATION OF PATIENT:_____EMPLOYER:_____

BUSINESS ADDRESS: _____CITY:_____ ZIP CODE: _____

NAME OF SPOUSE: _____OCCUPATION OF SPOUSE: _____

EMPLOYER_____BUSINESS TELEPHONE: _____

WHY ARE YOU SEEING DR. KING? (Chief Complaint)

_____

_____

NAME OF INTERNIST OR PRIMARY CARE PHYSICIAN?
_____TEL:_____

WHO REFERRED YOU TO DR. KING?
_____TEL:_____

PLEASE FURNISH THE NAME OF A RELATIVE OR FRIEND WE CAN CONTACT IN AN EMERGENCY (NOT YOUR SPOUSE)

NAME:_____RELATIONSHIP:_____

HOME TELEPHONE:_____BUSINESS TELEPHONE:_____

ADDRESS:_____

DO YOU HAVE MEDICAL INSURANCE? YES:_____ NO:_____ INSURED I.D.#:_____

NAME OF SUBCRIBER:_____INSURED GROUP #:_____

NAME OF INSURANCE:_____TELEPHONE:_____

PLEASE READ CAREFULLY:

I HEREBY AUTHORIZE MY INSURANCE CARRIER TO RELEASE INFORMATION REGARDING MEDICAL BENEFITS PAYABLE UNDER MY POLICY, AND TO PAY MEDICAL BENEFITS DIRECTLY TO WESLEY A. KING, M.D., A MEDICAL CORPORATION.
I HEREBY AUTHORIZE ANY MEDICAL CARE PROVIDER TO RELEASE ANY MEDICAL RECORDS AND REPORTS CONCERNING MY ILLNESS AND/ OR TREATMENT DIRECTLY TO WESLEY A. KING, M.D. A PHOTOCOPY OF THIS AUTHORIZATION IS AS VALID AS THE ORIGINAL.

_____ _____
SIGNATURE OF PATIENT OR GUARDIAN DATE

MEDICAL HISTORY

Were you ever hospitalized?-if so when:_____

Were their any complications?-
_____

Were you in the ICU?- YES ___ NO ___ Are you allergic to Latex?- YES ___ NO ___

Past Surgeries:
_____

_____

Chronic Medical Conditions:
_____

Allergic to any Medications?-
_____

_____

Current Medications: (if more space is needed, please use the back of this sheet)

Name	Dosage Frequency	Reason for taking
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Family Medical History: (what illnesses run in your family?)-
_____

_____

_____

Siblings: (brothers/sisters)
_____

SOCIAL HISTORY

Do you smoke? YES ____ NO_____ How many a day? _____ How many years? _____

Do you drink alcohol? YES ___ NO ____ How often? _____ How many years?_____

Place an X in the appropriate box if the patient has been diagnosed with any of the following illnesses

Neurological Problems (Brain/Spine)
- Stroke YES ___ NO ___
- Seizures YES ___ NO ___
- Tumor YES ___ NO ___
- Disc Disease YES ___ NO ___

Cardiovascular Problems (Heart)
- Congenital Heart Defect YES ___ NO ___
- Heart Murmur YES ___ NO ___

Respiratory Problems (Lungs)
- Asthma/Wheezing YES ___ NO ___
- Pneumonia YES ___ NO ___

Endocrine Problems (Hormones)
- Thyroid YES ___ NO ___
- Diabetes YES ___ NO ___
- Growth Delay YES ___ NO ___

Gastrointestinal Problems (Stomach/Colon)
- Reflux (spitting up) YES ___ NO ___

Genitourinary Problems
- Renal Dysfunction YES ___ NO ___
  - Kidney Infections YES ___ NO ___
- Urinary Tract Infections YES ___ NO ___

Dermatology Problems (Skin)
- Rash YES ___ NO ___
- Eczema YES ___ NO ___

Ophthalmology Problems (Eyes)
- Strabismus (eye crossing) YES ___ NO ___
- Nystagmus (eye shaking) YES ___ NO ___
- Blurred Vision YES ___ NO ___

Hematological Problems (Blood)
- Bleeding Problems YES ___ NO ___
- Anemia YES ___ NO ___

Otolaryngology Problems (Ear, Nose and Throat)
- Ear Infections YES ___ NO ___
- Sinus Problems YES ___ NO ___

Musculoskeletal Problems	YES ___	NO ___
Psychiatric Problems		
Depression	YES ___	NO ___
ADD/ADHD	YES ___	NO ___
Risk for Exposure to HIV	YES ___	NO ___
Past History of Hepatitis	YES ___	NO ___
Past Blood Transfusions ____	YES ___	NO ___
Possible Pregnancy (women of childbearing age)	YES ___	NO ___

Signature of Patient/Parent _____
Date: _____