1623 NE BROADWAY
PORTLAND, OR 97232
503-286-4400
FAX: 503-286-4944

Full Name____

What do you like to be called_____________________________ Preferred Pronoun_________________

Street Address____

City, State, Zip____

Birth date __________/___________/___________ Age_____________________________________

Phone: (home)___________________________ (cell)______________________ (work)____________________

Email Address ____

Marital Status (check one): Single_________Married______ Divorced_____ Widowed_____ Other _______

How did you hear about us?____

In case of emergency please contact: Name ______________________________ phone: ___________________

BY WAY OF SIGNATURE, I AUTHORIZE TREATMENT AND ACCEPT FINANCIAL RESPONSIBILITY. IF MY INSURANCE DOES NOT PAY, I AM RESPONSIBLE FOR ALL BALANCES ON MY ACCOUNT. I UNDERSTAND THAT PAYMENT IS DUE AT THE TIME OF SERVICE. MY SIGNATURE ALSO GIVES PERMISSION TO EXCHANGE INFORMATION WITH MY INSURANCE COMPANY/S TO OBTAIN PAYMENT.

Patient Signature____ Date ____________________

Parent or Guardian Signature__________________________________ Date ____________________

For Hormone Optimization Patients:

I understand that prescriptions will not be written or extended 12 months after the date of my last appointment. ________
Initial

Reason for seeing Dr. David:____

____

____

GENERAL HEALTH HISTORY

What diseases or medical problems have you had in the past? (for example: heart disease, stroke, cancer, arthritis, diabetes, hypertension, bipolar disorder, anxiety, depression, attention deficit disorder, etc.)__________

____

____

Surgical History (***unrelated to pain***; such as appendectomy, hysterectomy):________________________________

____

Allergies (include medication and food allergies): ____

____

Current Medications (include dosages and schedules): ____

____

____

Past Medications:
List medications you have taken in the past and have discontinued because they were ineffective or caused intolerable side effects:____

____

Do you have any of the following symptoms? (Circle all that apply) NONE (Circle if none apply)

Headaches	Stomach Pain	Chest Pain
Vision Problems	Nausea	Shortness of Breath
Hearing Problems	Vomiting	Urinary Problems
Dizziness	Constipation	Rashes
Difficulty Swallowing	Diarrhea	Swollen Joints
Chronic Fatigue	Other:____	

YOUR HISTORY

What is your current Height? _________ What is your current weight? _________

TOBACCO USE

Do you presently smoke cigarettes or use tobacco in any form? Yes No

If not, did you ever smoke cigarettes or use tobacco in any form? Yes No

How many packs do (did) you smoke a day?__________________ For how long?________________

Have you tried to quit smoking and later resumed?____________ How many times?_____________

Are you currently under a doctor's care?

Doctor's Name **Reason** **Last Seen**

____

____

Please note anything else you feel the doctor should know:

____

____

____

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____

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