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

Patient's Full Name____

Street Address____

City, State, Zip____

Birth date ___________/____________/____________ Age____________________________________

Phone: (home)__________________________ (cell)_____________________ (work)___________________

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

Email Address ____

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 ___________________

_______ I have received and understand the Missed Appointment and Late Cancellation Policy.

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 all medications you have taken in the past and have discontinued, either 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:____	

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?_____________

YOUR HISTORY

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

What doctors have you seen?

Doctor's Name	Month/Year Seen	Reason for visit

Date of last lab tests

Name of Test	location	Month/Year Done

Please note anything else you feel the doctor should know:

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