

Rise Health

1623 NE Broadway · Portland, OR 97232
Phone: (503) 286-4400
Fax: (503) 287-3667

Full Name _____

What do you like to be called _____ Preferred Pronoun _____

Street Address _____

City, State, Zip _____

Gender: _____ 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: _____ Relationship: _____

Phone Number: _____

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:
