**RONALD D.ROSEN, MD, PC**
**OPEN PATHS**

918 NE 5th ST
BEND, OR 97701 541-388-3804

**PATIENT REGISTRATION FORM**
Please complete this form in its entirety.

Today's Date: ______________

Patient's Name: ________________________________________________________

Date of Birth________________ SS#_______________________ Sex M F
Address:_______________________________________________________________
City:____________________________________ State:_____ Zip:_________________
Home Phone:___________________ Work:_________________ Cell:______________
Email (optional if you want email correspondence) ______________________________

Employer/School:__________________________ Occupation: ____________________

Are you: Single Partnered Married Divorced Widowed
Do you live: Alone Partner Parents Other
Spouse/Partner's Name: _________________________________________________
Phone number/Numbers:_________________________________________________
Emergency Contact: ____________________________________________________

Can we call and leave a message in your phone number re: results, appointments? Y N
If not what phone may we use? _________________________
How did you find my practice? ____________________________________________
Do you have medical insurance: ____________________________________________
Do you have Medicare as your primary insurance?

**INSURANCE ACKNOWLEDGEMENT**

*ALL PATIENTS SIGN (INCLUDING MEDICARE)*

I__________________________ have been informed the Ronald D. Rosen, MD,PC and his office don't do any insurance billing and he has "opted out" of Medicare. I agree to pay in full all services provided by Dr. Rosen and understand that all payments for services and supplements are due at the time of service. I understand that I have a direct relationship as a client/customer with my insurance company and that Dr. Rosen will provide me with a receipt for each visit or supplement purchase. I understand that in some instances my insurance may not cover certain services provided by Dr. Rosen.

In most cases supplements are not covered by insurance. I also understand that Dr. Rosen has no direct relationship with any insurance company and is thus not an intermediary between my insurance company and myself.

Print Name:______________________________ Date:__________________________

Signature________________________________ Witness:________________________

(If a minor, parent's signature please)

MEDICARE PATIENTS ONLY

I___________________________________ enter into a private medical contract with Dr. Ronald D. Rosen. I understand that Dr. Rosen has "opted out" of Medicare. I agree to pay in full for all services provided by Dr. Rosen or his staff. I understand that Dr. Rosen is excluded by his own volition from participating in the Medicare program under section 1128 of the Social Security Act. I agree not to submit any claims or request Dr. Rosen to submit any claim for payment under Medicare, even if Medicare would otherwise cover such services and items. I acknowledge that Medigap will not pay towards the services and that other supplemental insurers may not pay either.

Signature:_________________________________ Witness:______________________

## I. WHAT ARE YOUR GOALS FOR THIS VISIT?

## II. CURRENT CONCERNS

Rank by order of priority
List onset, frequency and severity(mild/mod/severe)
*Example: Headache / June 2004 / 4x week*

1________________________________________________________________

2________________________________________________________________

3________________________________________________________________

4________________________________________________________________

5________________________________________________________________

## III. PAST MEDICAL HISTORY

| **Conditions** | **Have you ever experienced this?** | **Has a close family member?** | **Please explain.** |
|---|---|---|---|
| Cancer (type:________________) | Yes________ No________ | Yes________ No________ | |
| Depression | Yes________ No________ | Yes________ No________ | |
| Diabetes | Yes________ No________ | Yes________ No________ | |
| Digestive Disorders | Yes________ No________ | Yes________ No________ | |
| Heart Disease | Yes________ No________ | Yes________ No________ | |
| High Blood Pressure | Yes________ No________ | Yes________ No________ | |
| High Cholesterol | Yes________ No________ | Yes________ No________ | |
| Lung Disease (asthma, etc.) | Yes________ No________ | Yes________ No________ | |

| | | | |
|---|---|---|---|
| Liver Disease | Yes________ No________ | Yes________<br>No________ | |
| Seizures | Yes________ No________ | Yes________<br>No________ | |
| Stroke | Yes________ No________ | Yes________<br>No________ | |
| Thyroid Disease | Yes________ No________ | Yes________<br>No________ | |
| Other:________________ | Yes________ No________ | Yes________<br>No________ | |
| Other: ________________ | Yes________ No________ | Yes________<br>No________ | |
| Other: ________________ | Yes________ No________ | Yes________<br>No________ | |
| Other: ________________ | Yes________ No________ | Yes________<br>No________ | |

**1. Do you know if you have ever been exposed to harmful environmental substances?**

**2. Please list any medications to which you are allergic:**

**3. Please list any prescription medications you are taking now.**

**4. Please list any supplements, vitamins or herbs you are taking now.**

Please specify brand or manufacturer, Reason and Year Started
*Example: St. John's Wort / Feeling Down / 2010*

**5. Have you had any injuries or surgical procedures?**

**Type** **Date**

**6. What prior experiences have you had with complementary and alternative medicine?**

## IV. CURRENT CONDITIONS & SYMPTOMS

### PERSONAL HISTORY

**PLEASE CHECK ANY CONDITIONS OR SYMPTOMS YOU HAVE NOW**

| | | | |
|---|---|---|---|
| ☐ Arthritis | ☐ Liver/Gallbladder Disease | ☐ Stroke | ☐ Heart Disease |
| ☐ High/Low Blood Pressure | ☐ Hypoglycemia/Hyperglycemia | ☐ Kidney Disease | ☐ Elevated Blood Cholesterol |
| ☐ Cancer | ☐ Diabetes | ☐ Food Allergies/Intolerance | ☐ Diverticulitis/Irritable Bowels |
| ☐ Ulcer | ☐ Seizures | ☐ Hepatitis | ☐ Raynaud's Disease |
| ☐ Chronic Fatigue | ☐ Anemia | ☐ Thyroid Imbalance | ☐ Allergies |
| ☐ Fibromyalgia/Polymyalgia | ☐ Lyme Disease | ☐ Chronic Pain Condition | ☐ Impotence |
| ☐ Gastritis | ☐ Asthma | ☐ Infertility | ☐ Emphysema |

### FAMILY MEDICAL HISTORY

**PLEASE CHECK ANY CONDITION THAT APPLIES TO YOUR IMMEDIATE FAMILY.**

**PUT AN F (FATHER), M (MOTHER), S (SISTER), B (BROTHER), GM (GRANDMOTHER), GF (GRANDFATHER) NEXT TO CHOICE**

| | | | |
|---|---|---|---|
| ☐ Diabetes | ☐ Seizures | ☐ Heart Disease | ☐ Stroke |
| ☐ High Blood Pressure | ☐ Allergies | ☐ Cancer | ☐ Asthma |
| ☐ Other | | | |

**PLEASE CHECK IF YOU HAVE HAD ANY OF THESE SYMPTOMS LISTED IN THE LAST THREE MONTHS:**

**GENERAL**

| | | | |
|---|---|---|---|
| ☐ Poor Appetite | ☐ Poor Sleep | ☐ Fatigue | ☐ Fevers |
| ☐ Chills | ☐ Night Sweats | ☐ Sweat easily | ☐ Tremors |
| ☐ Cravings | ☐ Localized Weakness | ☐ Poor Balance | ☐ Change in Appetite |
| ☐ Bleed/Bruise Easily | ☐ Weight Loss/Gain | ☐ Peculiar Tastes/Smells | ☐ Dental/Gum Problems |
| ☐ Muscle Weakness/Fatigue | ☐ Strong Thirst (cold/hot drinks) | | |

**SKIN AND HAIR**

| | | | |
|---|---|---|---|
| ☐ Rashes | ☐ Ulcerations | ☐ Hives/Allergic Dermatitis | ☐ Itching |
| ☐ Eczema/Psoriasis | ☐ Dandruff | ☐ Loss of Hair | ☐ Moles |
| ☐ Skin Discolorations | ☐ Acne | ☐ Change in Skin/Hair Texture | ☐ Face Flushing |

**HEAD, EARS, NOSE, AND THROAT**

| | | | |
|---|---|---|---|
| ☐ Dizziness | ☐ Difficulty Swallowing | ☐ Migraines | ☐ Eye Glasses |
| ☐ Eye Strain | ☐ Eye Pain | ☐ Poor Vision | ☐ Night Blindness |
| ☐ Color Blindness | ☐ Cataracts | ☐ Blurred Vision | ☐ Earaches |
| ☐ Ringing in Ears | ☐ Poor Hearing | ☐ Spots in Front of Eyes | ☐ Sinus Problems |
| ☐ Nosebleeds | ☐ Recurrent Sore Throats/Colds | ☐ Teeth Grinding | ☐ Facial Pain |
| ☐ Headaches (where/when) | ☐ Dental Problems | ☐ Jaw Clicks/Locks | ☐ Sores on Lips/Tongue |

**CARDIOVASCULAR**

| | | | |
|---|---|---|---|
| ☐ Chest Pain | ☐ Irregular Heartbeat | ☐ Palpitations at Rest | ☐ Fainting |
| ☐ Cold Hands/Feet | ☐ Swelling of Hands/Feet | ☐ Blood Clots | ☐ Phlebitis |
| ☐ Shortness of Breath | ☐ Varicose/Spider Veins | ☐ Pressure in Chest | |

**RESPIRATORY**

- ☐ Cough
- ☐ Coughing Blood
- ☐ Asthma
- ☐ Bronchitis
- ☐ Pneumonia
- ☐ Pain with Deep Inhalation
- ☐ Tight Sensation in Chest
- ☐ Wheezing
- ☐ Difficult to Inhale/Exhale
- ☐ Production of Phlegm

Any Other Lung Condition:

**GASTROINTESTINAL**

- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Gas
- ☐ Belching
- ☐ Black Stools
- ☐ Blood in Stools
- ☐ Indigestion
- ☐ Bad Breath
- ☐ Rectal Pain
- ☐ Hemorrhoids
- ☐ Bloating/Edema
- ☐ Chronic Use of Laxatives
- ☐ Loose Stools (> 2 per day)
- ☐ Abdominal Pain/Cramps
- ☐ Changes in Appetite
- ☐ Acid Reflux
- ☐ Hernia

Any Other Problems with Your Stomach/Intestines:

**UROGENITAL**

- ☐ Pain on Urination
- ☐ Frequent Urination
- ☐ Blood in Urine
- ☐ Urgent Urination
- ☐ Unable to Hold Urine
- ☐ Kidney Stones
- ☐ Scanty Flow
- ☐ Copious Flow
- ☐ Impotence
- ☐ Sores on Genitals
- ☐ Urinary Tract Infections
- ☐ Burning Urination
- ☐ Premature Ejaculation
- ☐ Decreased Libido
- ☐ Prostatitis
- ☐ Dribbling after Urination

Do You Wake to Urinate? ☐ Yes ☐ No

What Times: ____________________

What Color is Your Urine: ____________________

Any Other Problems with Your Genital or Urinary System?

**GYNECOLOGICAL/REPRODUCTIVE**

No. of Pregnancies ______
Age of First Menses ______
☐ Ovarian Cysts
☐ Breast Lumps

No. of Births ______
Date of Last Menses ______
☐ Vaginal Sores
☐ Fibrocystic Breast Tissue

No. of Miscarriages ______
Date of last PAP/Pelvic ______
☐ Vaginal Discharge
☐ Fibroid Tumors

No. of Premature Births ______
☐ Painful Menses
☐ Vaginal Dryness
☐ Infertility

No. of Abortions ______
☐ Irregular Menstruation
☐ Difficult Intercourse
☐ Endometriosis

Are you Pregnant? ☐ Yes ☐ No

Do You Practice Birth Control? ☐ Yes ☐ No

What Type? ____________________

How Long:

**MUSCULOSKELETAL**

- ☐ Neck Pain
- ☐ Shoulder Pain
- ☐ Hand/Wrist Pain
- ☐ Carpal Tunnel
- ☐ Knee Pain
- ☐ Sprains/Strains
- ☐ Sciatica
- ☐ Foot/Ankle Pain
- ☐ Hip Pain
- ☐ Muscle Pain
- ☐ Muscle Weakness
- ☐ Tendonitis
- ☐ Bursitis
- ☐ Rotator Cuff
- ☐ Back Pain - lower
- ☐ Back Pain - middle
- ☐ Back Pain - upper

**NEUROPSYCHOLOGICAL**

- ☐ Seizures
- ☐ Loss of Balance
- ☐ Vertigo/Dizziness
- ☐ Areas of Numbness
- ☐ Lack of Coordination
- ☐ Poor Memory
- ☐ Concussion
- ☐ Depression
- ☐ Anxiety/Panic Attacks
- ☐ Bad Temper/Irritable
- ☐ Easily Susceptible to Stress
- ☐ Seasonal Affective Disorder

Have you ever been treated for emotional problems? ☐ Yes ☐ No

Do you have a spiritual life? ☐ Yes ☐ No

Have you every considered or attempted suicide? ☐ Yes ☐ No

Have you ever been treated for substance abuse? ☐ Yes ☐ No

Any other neurological or psychological conditions? If yes, please explain:

Indicate on the scale your satisfaction in family relationships Satisfied -------------------------------------- Distressed

Indicate on the scale your satisfaction in intimate relationships Satisfied -------------------------------------- Distressed

Indicate on the scale your satisfaction in working relationships Satisfied -------------------------------------- Distressed

## V. PERSONAL & LIFESTYLE HISTORY

**1. Substance Usage**

| | Type | Frequency | Currently? | Quit? |
|---|---|---|---|---|
| Tobacco? | | | | |
| Alcohol? | | | | |
| Other drugs? | | | | |

**2. What is your occupation?**

**3. What are your hobbies and interests?**

**4. How do you spend your day?**

**5. With whom do you live? (Include roommates, spouse, children, relatives, pets, etc.)**

**6. In what physical activities do you participate?**

| Activity | Frequency | Duration | Intensity |
|---|---|---|---|

**7. Do you have a meditation, Yoga, other form of spiritual practice?**

**8. What do you do to relax?**

**9. Are you happy?**

**10. What gives you a sense of meaning and purpose? If it feels appropriate, describe how spirituality or religion fits into your life, or how it has in the past.**

**11. What is your typical diet like:**

Breakfast:

Lunch:

Dinner:

**12. What do you drink in an average day?**

**13. What kind of oils do you use to cook?**

**14. Do you have any food allergies or intolerances?**

**15. Are there any types or groups of food you crave or eat a lot?**

**16. Are there any types or groups of food you dislike or rarely eat?**

**17. How many servings of fruit do you eat/drink each day?**
*Serving = 1 small piece of fruit, 1/2 cup of juice, 1/2 cup canned or chopped fruit, 1/4 cup dried fruit*

**18. How many servings of vegetables do you eat/drink each day?**
*Serving = 1/2 cup raw or cooked, 1 cup fresh, green leafy vegetables, 1/4 cup dried or 1 small piece*

**19. Are you currently on a special diet? If so, please describe:**

**20. How would you describe your relationship with food?**

**21. Do you have any other comments or things you would like to discuss?**

| ______________________ | ______________________ | ______________________ |
|---|---|---|
| **PRINTED NAME** | **SIGNATURE** | **DATE** |