Forouz Jowkar Functional Medicine
2019 Galisteo St, N10, Suite D
Santa Fe, New Mexico, US - 87505

Patient Agreement

This agreement is between (patient name):
*

and Forouz Jowkar, PA-C, LLC.

Welcome to my Functional Medicine Practice.

To avoid any misunderstandings, please take your time reading this agreement. It is important that you understand what I expect from you, and also, what you may expect from me. I appreciate your time and cooperation.

Notice: This is a strictly fragrance-free office.

Many of my patients are chemically sensitive and cannot tolerate artificial scents such as perfumes, deodorants, fabric softeners, laundry detergents, shampoos, cigarette odor, lotions, etc., not strong non-artificial fragrances such as essential oils. Thank you for your cooperation in maintaining our fragrance free environment to protect them.

PROVIDER-PATIENT RELATIONSHIP

I do not treat patients for primary care, but will refer you to a provider of your choice.

As a patient, you are required to show proof of identity when necessary (i.e. Driver's License, Passport, etc.).

As a healthcare provider, I am dedicated to giving you the finest care that I believe can bring you the best treatment results. In return, I ask patients to show a strong sense of responsibility for their own health and well-being.

As a patient, you agree to:

–> ask questions when you don't understand any part of your medical care;
–> cooperate with the agreed upon treatment plan, or explain why cooperation is not possible;
–> keep scheduled appointments, or call to cancel on time (see cancellation policy);
–> update personal and medical information with each visit, such as change of address and other contact information, name, pregnancy, new medications and supplements and medical conditions, whenever there is a change.

HOW WE MAY COMMUNICATE WITH EACH OTHER

We may contact you regarding appointments, test results and other matters related to your healthcare at any of the addresses, fax and/or phone numbers that you have provided on the Patient Intake Form.

My intention is to respond to all patient inquiries. If you have left a phone message, sent a message via the online portal, sent a fax, or mailed an inquiry and have not received a response in a reasonable amount of time, you agree to call my office to make sure that we know you need to reach me.

Please give all calls, emails and requests five (5) office days (Tues, Wed, Thurs, except for holidays) to respond.

We are a busy office with limited hours and may not be able to get to your call/request sooner. This includes but is not limited to medication requests, records requests or general questions. If you need to come pick up anything (an order, supplements, test kit, etc.), please call ahead to make sure someone will be available in the office.

You may communicate with my office about medical issues by phone, fax, mail, or your online portal only. We do not use email for medical information or consults as our email is not HIPAA compliant at this time.

Please note that all communication with either Forouz or the front desk should go through the portal.

In the rare exception that anyone should decide to email us using the gmail account, it CANNOT be related to your case medically in any way or we cannot respond to it.

All recent labs will be uploaded to your portal and shared that way. If you choose not to set up a portal account, you will receive your labs when you come in for an in-person appointment or they will be mailed to you in regular mail as per request.

There is a word limit in the portal messaging system. If your message is too long for the portal, please do not send multiple messages. Instead, make a 15 minute appointment with Forouz. Messages are meant to be short communication and anything longer should be an appointment.

As a patient, you agree to actively participate and communicate with this office 10 working days after you have completed a lab or other diagnostic test. We encourage this to ensure that we have indeed received your test results. Test results will be discussed with you during an appointment only.

If we receive abnormal test results ordered by another provider, that provider would counsel you directly about those results. However, you may request additional counseling from me by scheduling an office visit.

The office has an email mailing list for our newsletter (no more than once a month) which includes important office announcements regarding hours, policies, and current regulations. In order to stay informed and have the best office experience possible, we encourage you to sign up for our mailing list on the Patient Intake Form.

REGARDING LABORATORY TESTING

Lab testing will most likely be needed in order to treat you. Although we have opted out of insurance, if you have a PPO plan your general labs (or bloodwork) should continue to be covered by your insurance carrier. However, it is always a good idea to check with your insurance to ensure there are no surprises.

This also holds true for regular Medicare and Medicaid Patients. Medicare-Advantage plans and HMOs may not cover your labs. For these patients, and for those with high deductibles or for those patients who do not have insurance, we offer some testing at discounted rates through Lab Corp and Ulta Labs. Our main focus and priority is serving our patients to the best of our ability and to do so at reasonable prices. We are continually striving to meet patient needs and will continue to work with labs to get the best pricing available. As an example of what we have been able to negotiate: a Whole Blood Histamine Test through Lab Corp (through Insurance) runs approximately $300+. We can offer that same test through our office for $68. Please note that some specialty labs may not be covered at all by any insurance.

POLICIES FOR PATIENTS LESS THAN 18 YEARS OF AGE

Any patient under 18 years of age must be accompanied by a parent or legal guardian during each visit. Proof of identity should be provided at the time of the first visit (School ID, Birth Certificate, etc.). If the patient is a minor or legally incapacitated, the parent or legal guardian agrees that he/she has the legal authority to authorize Forouz Jowkar, PA-C to treat the patient.

MEDICATION RENEWAL

As a patient, you are responsible to inform me at every visit of any change in medications or supplements that you decided to implement without my consult. Your medication renewal is subject to my periodic review of your health status to assess need and to monitor therapy.

As a patient, you must legally maintain your status as an "active" patient (in order to be eligible for any prescription renewals) by scheduling an in person appointment at least once a year. You agree to promptly make a follow-up office visit when you are notified of this requirement prior to annual renewal of your prescription(s). If you need a prescription, please ensure that you request this and give me at least five (5) office days to respond. Please note that if I am out of town, there may be an additional delay so monitor your medications closely.

PAYMENT POLICIES AND INSURANCE

My practice has no agreement with any health insurance company, including PPO, POS, HMO, IPA, Medicare, Medicaid, or any government program. This means that I do not accept insurance; you are responsible for paying me directly at the time of service.

Payment at time of service may be by cash, check or credit card.

For patients with PPO coverage, we can provide you with a "Super Bill" which you can submit to your insurance carrier. Super Bills will be provided by mail upon request by patient when checking out. As a patient, you understand that this medical practice is not responsible for any payment decisions made by your insurance carrier.

This medical practice is not a Medicare provider. Medicare patients who are interested in receiving services from Forouz Jowkar, PA-C, even though Medicare will not reimburse, need to review and sign an ABN form (Advance Beneficiary Notice of Non-Payment).

To review an ABN form, please call my office or send an email inquiry. We will forward the form to you by mail, email or fax.

As a patient in my practice, you agree that you do not expect to receive reimbursement from Medicare and you must indicate this fact by checking the appropriate box for Option 2 on the ABN form, signing it and sending it to my office by mail, fax, or email attachment.

Note: I cannot accept you as a patient if you check Option 1 on the ABN form.

This is simply because I do not file claims with Medicare. If you are expecting Medicare to reimburse you for services you receive as my patient, then please consider that this may not be the right practice for you.

Once we receive your signed ABN form, I will determine if I can offer you an appointment and see you as a patient.

FEES FOR LABORATORY AND DIAGNOSTIC TESTS

A Functional Medicine practice may require laboratory and diagnostic tests not commonly ordered by conventional medical practitioners, and these tests may or may not be covered by insurance carriers. Such tests may provide critical information for diagnosis and treatment. As a patient, you are responsible for checking with your insurance carrier for any diagnostic tests in order to see if they are covered. My practice is not responsible for your insurance carrier's failure to pay for your diagnostic tests or laboratory work.

Medicare and Medicaid patients' labs may be covered according to Medicare and Medicaid rules and limitations, even though I do not receive payment for office visits from them.

PPO insurance carriers may pay for tests ordered by me, and treat them as if ordered by an out of network provider.

HMO Patients may want to discuss the payment arrangement with their carriers to see if labs are covered when ordered by an out of network provider.

As a healthcare provider, I have arranged with some laboratories to provide diagnostic tests at a large discount. If your insurance does not cover all or some of the cost of your tests, you could consider paying the cost of those labs via our office at a much discounted rate. I can discuss these arrangements with you during your office visit.

FEES

All consultation fees are based on an hourly rate broken down into 15 minute increments. If an appointment goes over by 5 minutes, charges will go to the next bracket. The initial consultation is set for an estimate of 90 minutes. This is an estimate only and the consultation may go above or below that time. Charges will be based on the time you complete, not the time you book. This is true for all appointments going forward.

A phone consultation must be pre-arranged like any other appointment. The fee will be based on elapsed time, at the same rates as an office visit. Secure payment is required. Ask for details from my office when ready to make a phone appointment.

There is no charge for a call to ask questions about your previous office visit, if made within three days after that visit.

Any time spent per request to discuss a patient's case with another doctor will be billed to the patient at the same hourly rate as an appointment.

Fees for I.V. treatments and injections are separate from any medical consult. There will be an additional charge for any medical consultation with you during a treatment.

There will be a fee for letter or report preparation based on the time spent to complete this task. The fee is due when the report is ready, for services including: exemption from jury duty for medical reasons, school, immigration, airline and health club, life and health insurance, disability, and medical-legal forms. You can request a copy of your entire medical file or part of your records for a flat fee of $25 plus postage (Priority Mail or similar). Records will not be provided until payment has been received. There is no fee for one-time copying of pertinent records to another physician upon written request.

NO-SHOW AND APPOINTMENT CANCELLATION POLICY

Please call my office at least 24 hours prior to a scheduled appointment if you need to make a change or cancel your appointment.

New patients who fail to call at least 24 hours prior to their appointment to reschedule or who no-show for their appointment will be charged the full amount of the appointment time that was missed.

For all follow up visits that are late-cancelled or missed, a $75 charge will be incurred regardless of the length of time scheduled.

Missed or late-cancelled I.V.s or injections will be 50% of treatment. Policies and pricing are subject to change and notices will be posted in office.

TERMINATION OF AGREEMENT

The patient or provider can terminate this agreement without providing an explanation. If you choose to terminate, please let the office know that you no longer wish to be a patient. If the provider decides to terminate, she will provide you a notice in writing. At least 30 days from the date of the notice, she will remain available if you choose to consult with her until the effective date of termination for emergency treatment and prescriptions in order to give you time to find a replacement provider. She will also refer you to another practitioner to facilitate that transition.

A copy of this agreement is deemed as valid as the original.

By signing below, I confirm that I have read and agree to the Patient Agreement and Notice of Privacy Practices for the office of Forouz Jowkar, PA-C, Ph.D. This contract becomes effective upon first visit with the provider, not prior.

PATIENT SIGNATURE * _____

Date: * _____

PARENT/GUARDIAN SIGNATURE (if under 18): _____

Date: _____

Notice of Privacy Practices

THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT.

PLEASE REVIEW THIS NOTICE CAREFULLY.

In compliance with the Health Insurance Portability and Accountability Act (HIPPA) and Health and Human Services Regulations – Effective April 21, 2003 – this notice describes how medical information about you may be used, how it may be disclosed, and how you may get access to this information.

Medical information about you is collected and stored as needed for treatment in the form of a personal history, treatment plan, treatment plan reviews, and progress notes on each session. This information is considered Protected Health Information or PHI. If you pay by insurance or other third party, I am often required to report your current diagnosis and progress in treatment. This report is either made by postal mail, fax or electronic mail. You are entitled to know the specific information your insurance company or other third party requires, and may request a copy of it at any time.

Disclosure of your PHI will only be made with your prior written authorization and consent. Please note these exceptions:

According to New Mexico state law, I am required to disclose your PHI in the event you are a danger to yourself or others or if you are involved in or report to me the abuse or neglect of a child or elderly person.

I may be required to disclose your PHI for reasons of national security.

I may be required to disclose your PHI if I receive a subpoena.

You may revoke your authorization, in writing, at any time.

Your Rights With Regard to Your Personal Health Information:

You have the right to request restrictions on certain uses and disclosures of your PHI. Your request will be honored whenever possible. Any denial of your request will be discussed with you.

You have the right to amend your PHI.

You have the right to receive an accounting of disclosures of your PHI when it is released for reasons other than treatment, payment and healthcare operations.

You have the right to receive a paper copy of this notice.

If you have any complaint with how your PHI has been handled, or if you believe your privacy rights have been violated, you may speak directly with me, or you may file a complaint with the Secretary of the U.S. Department of Health and Human Services. Your care will not be limited and action will not be taken against you if you file a complaint.

My Legal Duties:

I am required by law to protect the privacy of your individually identifiable health information, and to provide you with this notice.

I am required to abide by the terms of this notice.

In the event that my privacy practices or duties change, I am required to advise you of any changes in writing.

Forouz Jowkar Functional Medicine
2019 Galisteo St, N10, Suite D
Santa Fe, New Mexico, US - 87505

Patient Intake & Confidential Health History

Full Legal Name (First, Last, Middle Initial): *

Preferred Name: *

Age: *

Date of Birth: *

Primary Phone Number (specify Home/Work/Cell): *

Secondary Phone Number (specify Home/Work/Cell):

Address: *

Email Address*: *

Please be aware that email is not a secure form of communication. Subsequently, email will not be used for any medical information or consults.

Gender: *

☐ Female ☐ Male ☐ Custom/Other
☐ I'd prefer not to answer

How would you like to be addressed? (he/him, she/her, ze, they, or something else):

Are you: *

☐ Single ☐ Married ☐ Other

Occupation(s):

In your occupation(s), are you (check all that apply):

☐ Full-time ☐ Part-time ☐ Gig Worker
☐ Student ☐ Retired ☐ Other

Current Employer(s)/School(s):

Emergency Contact (Name, Relationship): *

Emergency Contact's Phone: *

What is the best phone number to communicate with you between office visits? ☐ Home ☐ Cell ☐ Work

Is there any place you do NOT want me to leave a message? _____

Would you like to receive an email newsletter with news and updates from the office of Forouz Jowkar, PA-C, Ph.D.? ☐ Yes ☐ No

How did you hear about us? _____

Primary Insurance Details

NOTE: This section is optional unless you have PPO insurance. We are not in any insurance networks, but we can provide you with Super Bills for your visits if you are enrolled in a PPO plan.

Insurance Type: ☐ Medicare ☐ Medicaid ☐ Tricare champus ☐ CHAMPVA ☐ Group Health Plan ☐ FECA Blk Lung ☐ Other

Plan or program name: _____

ID#: _____

Policy Group/FECA #: _____

Payer Name: _____

Primary Insured Name: _____

Primary Insured Date of Birth: _____

Primary Insured Relationship _____

Confidential Health History Questionnaire

What are the concerns for which you are seeking care? (Primary concern first)

Concern 1: *

Date of Onset: * _____

Concern 2:

Date of Onset: _____

Concern 3:

Date of Onset:

Concern 4:

Date of Onset:

Name of Primary Care Physician:

For what concern did you last receive health or medical care?

What medications (prescribed or over-the-counter), herbs, vitamins, supplements, etc. are you currently taking?

Medications:

Supplements/Vitamins:

Herbs, Medicinal Teas, etc.

Do you follow a special diet? If yes, please describe:

Do you have any known contagious diseases at this time? ☐ Yes ☐ No

If yes, what?

FAMILY HISTORY

MOTHER

Age, if living:

Illnesses:

Age at Death, if applicable:

Cause of Death, if applicable:

FATHER

Age, if living:

Illnesses:

Age at Death, if applicable:

Cause of Death, if applicable:

BROTHER(s)

Age(s), if living:

Illnesses:

Age(s) at Death, if applicable:

Cause(s) of Death, if applicable:

SISTER(s)

Age(s), if living:

Illnesses:

Age(s) at Death, if applicable:

Cause(s) of Death, if applicable:

CHILDREN

Age(s), if living:

Illnesses:

Age(s) at Death, if applicable:

Cause(s) of Death, if applicable:

PATERNAL GRANDPARENTS

Age(s), if living:

Illnesses:

Age(s) at Death, if applicable:

Cause(s) of Death, if applicable:

MATERNAL GRANDPARENTS

Age(s), if living:

Illnesses

Age(s) at Death, if applicable:

Cause(s) of Death, if applicable:

Have you ever had any of the following childhood illnesses? (Check all that apply)

☐ Scarlet Fever ☐ Diptheria ☐ Rheumatic Fever
☐ Mumps ☐ Measles ☐ German Measles
☐ Others

Have you had any immunizations? ☐ Yes ☐ No

Negative reactions to immunizations? ☐ Yes ☐ No

If yes, explain:

Any other past medical history?

Hospitalizations, Surgery, X-Ray and Special Studies

What hospital-based surgeries, x-rays or special studies have you had? List the name and the year for each one:

Allergies

Are you hypersensitive or allergic to foods, drugs or environmental substances?
Please list:

Please answer questions below or check any of the following you have or have had in the past 6 months.

GENERAL

Height:

Weight: _____

Weight one year ago: _____

Maximum (non-pregnant) weight: _____

When were you at your maximum weight? _____

LIFESTYLE HABITS

Main interests and hobbies?

Do you exercise? ☐ Yes ☐ No

If yes, what kind and how often?

Do you have a religious/spiritual practice? ☐ Yes ☐ No

Are you able to average 6-8 hours of sleep? ☐ Yes ☐ No

Do you usually feel refreshed when you wake up? ☐ Yes ☐ No

Do you have regular contact with pets or livestock? ☐ Yes ☐ No

If yes, what kind?

Do you live alone? ☐ Yes ☐ No

Do you feel safe in your living situation? ☐ Yes ☐ No

History of Abuse? ☐ Yes ☐ No

Major Traumas? ☐ Yes ☐ No

Use of recreational drugs: ☐ Yes ☐ No

Treated for drug dependence: ☐ Yes ☐ No

DO YOU:

Drink coffee? ☐ Yes ☐ No

Drink black or green tea? ☐ Yes ☐ No

Drink cola or other sodas? ☐ Yes ☐ No

Add salt to your food ☐ Yes ☐ No

Eat refined sugar ☐ Yes ☐ No

Enjoy your work ☐ Yes ☐ No

Take vacations ☐ Yes ☐ No

Spend time outside ☐ Yes ☐ No

Watch TV? ☐ Yes ☐ No

If yes, how many hours per day or week? _____

Watch or engage in social media/online news/online videos? ☐ Yes ☐ No

If yes, roughly how many hours per day? _____

What time of day? Check all that apply. ☐ Morning ☐ Afternoon ☐ Evening ☐ Nighttime

Do you read books/print publications? ☐ Yes ☐ No

If yes, how often? _____

Use alcoholic beverages ☐ Yes ☐ No

per week: _____

Treated for alcoholism ☐ Yes ☐ No

Use tobacco currently ☐ Yes ☐ No

Used tobacco in the past ☐ Yes ☐ No

How many years? _____

How many packs or tins per day? _____

REVIEW OF SYMPTOMS

Check any of the following that you have or have had in the past 6 months.

SKIN

☐ Rashes ☐ Eczema, Hives ☐ Acne, Boils
☐ Itching ☐ Fungal Infections ☐ Color Change
☐ Hair Loss ☐ Dry Skin/Scalp ☐ Lumps
☐ Night Sweats ☐ Slow healing ulcerations ☐ Flushing or Hot Flashes

NOSE AND SINUSES	☐ Frequent colds	☐ Nose bleeds	☐ Stuffiness
	☐ Hay fever	☐ Sinus problems	☐ Loss of smell
EYES AND EARS	☐ Itchy eyes	☐ Watery eyes	☐ Dry eyes
	☐ Swollen/painful eyes	☐ Red eyes	☐ Impaired vision/blurriness
	☐ Light sensitivity	☐ Floaters in vision	☐ Cataracts
	☐ Color blindness	☐ Double vision	☐ Glaucoma
	☐ Hearing difficulty	☐ Ringing	☐ Earaches/Infection
MOUTH AND THROAT	☐ Sore throat	☐ Copious Saliva	☐ Teeth Grinding
	☐ Sore Tongue/lips	☐ Gum problems	☐ Hoarseness
	☐ Gagging/Choking	☐ Difficulty swallowing	
HEAD/NECK	☐ Headaches/Migraine	☐ Faintness	☐ Dizziness
		☐ Jaw pain	☐ Swollen glands
	☐ Goiter	☐ Pain or stiffness	☐ TMJ
RESPIRATORY	☐ Chest congestion	☐ Wheezing	☐ Asthma
	☐ Bronchitis/Pneumonia	☐ Emphysema	☐ Difficulty/Pain breathing
	☐ Shortness of breath	☐ Tuberculosis	☐ Cough (Wet)
		☐ Cough (Dry)	☐ Coughing blood
CARDIOVASCULAR	☐ Heart disease	☐ Angina/chest pain	☐ HIgh/Low blood pressure
	☐ Murmurs	☐ Blood clots	☐ Irregular heartbeats
	☐ Palpitations/fluttering	☐ Racing or pounding heart while at rest	☐ Swelling in legs/ankles/feet
			☐ Large swings in blood pressure and/or heart rate
CIRCULATION	☐ Easy bleeding or bruising	☐ Anemia	☐ Deep leg pain
		☐ Varicose veins	☐ Cold hands/feet
ENDOCRINE	☐ Hypothyroid	☐ Heat or cold intolerances	☐ Excessive sweating
	☐ Sweat less than normal or not at all	☐ Hypoglycemia	☐ Diabetes
		☐ Excessive thirst	☐ Excessive hunger
	☐ Fatigue	☐ Seasonal depression	
IMMUNE	☐ Chronic Fatigue Syndrome	☐ Chronic infections	☐ Chronically swollen glands
	☐ Slow healing wound		
MUSCLES/JOINTS/BONES	☐ Joint Pain	☐ Muscle Pain	☐ Muscle spasms/cramps
	☐ Hyperflexible joints	☐ Restless Leg Syndrome	☐ Sciatica
			☐ Osteoporosis

NEUROLOGICAL

- ☐ Seizures
- ☐ Paralysis
- ☐ Muscle weakness
- ☐ Numbness or tingling
- ☐ Head pressure
- ☐ Brain fog
- ☐ Easily stressed
- ☐ Vertigo or dizziness
- ☐ Loss of balance
- ☐ Tics

DIGESTION

- ☐ Trouble swallowing
- ☐ Heartburn/Acid reflux
- ☐ Change in thirst/appetite
- ☐ Ulcer
- ☐ Nausea/Vomiting
- ☐ Gas/bloating
- ☐ Belching/passing gas
- ☐ Diarrhea
- ☐ Constipation
- ☐ Pain or cramps
- ☐ Mucous in stool
- ☐ Black/bloody stool
- ☐ Hemmorrhoids
- ☐ Itchy/Burning anus
- ☐ Rectal pain
- ☐ Liver/gall bladder trouble
- ☐ Jaundice (yellow skin)

How often do you have a bowel movement currently? _____

Is this a change from before? _____

Consistency of Stools:

- ☐ Hard
- ☐ Firm
- ☐ Soft
- ☐ Loose

URINARY

- ☐ Pain on urination
- ☐ Increased frequency
- ☐ Frequency at night
- ☐ Frequent infections
- ☐ Inability to hold urine
- ☐ Full bladder but no urge to urinate
- ☐ Kidney stones
- ☐ Pain or stiffness
- ☐ Blood in urine

MENTAL/EMOTIONAL

- ☐ Mood swings
- ☐ Anxiety or nervousness
- ☐ Self-harm (cutting, etc.)
- ☐ Considered/Attempted suicide
- ☐ Depression
- ☐ Poor Concentration
- ☐ Other

If you checked "Other," please describe:

GENERAL

- ☐ Poor sleep/insomnia
- ☐ Dream disturbed sleep
- ☐ Fatigue/Low energy
- ☐ Generally feel hot
- ☐ Generally feel cold
- ☐ Unable to recover after exertion
- ☐ Chills
- ☐ Fevers
- ☐ Poor Appetite
- ☐ Constant hunger
- ☐ Hungry but feel full very quickly
- ☐ Peculiar taste in mouth
- ☐ Low libido
- ☐ Extremely high libido
- ☐ Experience High stress

Do you experience any cravings? If yes, please list: _____

Forouz Jowkar Functional Medicine
2019 Galisteo St, N10, Suite D
Santa Fe, New Mexico, US - 87505

MALE PHYSIOLOGY ONLY:

☐ Hernias ☐ Testicular masses ☐ Testicular pain
☐ Prostate disease ☐ Sexually transmitted disease ☐ Discharge or sores
☐ Sexual dysfunction

Are you sexually active? ☐ Yes ☐ No

Sexual orientation: _____

Birth control? ☐ Yes ☐ No

If yes, what type? _____

FEMALE PHYSIOLOGY ONLY:

☐ Irregular cycles ☐ Bleeding between cycles ☐ Pain during intercourse
☐ Clotting ☐ Heavy or excessive flow ☐ PMS
☐ Endometriosis
☐ Difficulty conceiving ☐ Painful menses ☐ Chronic Pelvic Pain
☐ Vaginal odor ☐ Ovarian cysts ☐ Menopausal symptoms
☐ Abnormal PAP ☐ Sexually transmitted disease ☐ Breast pain/tenderness
☐ Nipple discharge

Vaginal Discharge? ☐ Yes ☐ No

If yes, what color? _____

Age at which menses began: _____

Age of last menses (if menopausal): _____

Length of flow (First day of period to first day of next period): _____

Date of last period? _____

Are you sexually active? ☐ Yes ☐ No

Sexual orientation? _____

Do you use birth control? ☐ Yes ☐ No

If yes, what type? _____

Number of pregnancies: _____

Number of live births: _____

Number of miscarriages: _____

Number of abortions: _____

Number of difficult or premature births

Do you do breast self-exams? ☐ Yes ☐ No

Date of last pap smear? _____

Date of last mammogram? _____

Could you be pregnant now? ☐ Yes ☐ No

Any other feminine difficulties?

Additional comments or symptoms not listed:

Please list any additional major symptoms that were not listed in this form:

By signing below, I verify that the above information is correct and true to the best of my knowledge.

PATIENT SIGNATURE: * _____

Date: * _____