Forouz Jowkar, PA-C, Ph.D.
1925 Aspen Drive, Suite 100B
Santa Fe, NM 87505
505.424.9172 (Office)
505.438.1814 (Fax)

Date: _____

Full Legal Name:_____/_____/_____
(First Name) (Last Name) (Middle Initial)

Preferred Name:_____Age:_____Date of Birth:_____

Telephone #:_____/_____/_____
(home) (work) (cell)

Address:_____

Mailing Address:_____

Email Address:_____Gender:_____Female_____Male

Are you (check one): Single_____ Married_____ Other_____ Partner's Name:_____

Occupation:_____ (circle) Full-time / Part-time / Student / Retired

Employer / School:_____

Address:_____

Emergency Contact:_____
(Name) (Relationship)

_____/_____
(Day Phone) (Evening Phone)

What is the best way to communicate with you between office visits? (Home, Cell, Work)
Is there any place you do **NOT** want me to leave a message?_____

Please be aware that e-mail is not a secure communication, subsequently, e-mail will not be used for any medical information or consults.

Insurance Information - Please provide copy of front and back of insurance card.

Group Insurance: Insurance Co:_____

Insured Full Legal Name:_____DOB:_____

Driver's License Number:_____Exp Date_____Issuing State:_____

Confidential Health History Questionnaire

Name:_____ Date of Birth:_____

What are the concerns for which you are seeking care? (Primary concern first)
1._____Date of Onset:_____
2._____Date of Onset:_____
3._____Date of Onset:_____
4._____Date of Onset:_____

Name of Primary Care Physician:_____
What concern did you last receive health or medical care for?_____

What medications (prescribed or OTC), herbs, vitamins, supplements, etc are you currently taking?
_____

_____

_____

Check those that you currently use:

___Laxatives	___Pain relievers	___Antacids	___Cortisone
___Antibiotics	___Heart/Blood Medications	___Allergy Medication	___Thyroid Medication
___Sleeping Pills	___Anti-depressants	___Birth Control	___Hormones

Do you have any known contagious diseases at this time? _____ No _____Yes
If yes, what? _____

FAMILY HISTORY

	Father	Mother	Brothers	Sisters	Children	Paternal Grandparents	Maternal Grandparents
Ages (If living)							
Illnesses							
Age at Death							
Cause of Death							

Name:_____ Date of Birth::_____

Indicate if there have been any of the following diseases in you, your parents, grandparents, brothers, sisters or children. Please indicate the number of relatives who have/had the disease.

Cancer_____
Epilepsy_____
High Blood Pressure_____
Neuro Degenerative Disorders_____
Endocrine Disorders_____
Asthma_____
Arthritis_____

Diabetes_____
Heart Disease_____
Stroke_____
Kidney Disease_____
Allergies_____
Mental Illness_____
AutoImmune disorders_____

Have you ever had any of the following childhood illnesses (check if yes)

Scarlet Fever_____ Diphtheria_____ Rheumatic Fever_____ Mumps_____ Measles_____
German Measles_____

Have you had any immunizations? _____Yes _____No Negative Reactions? _____

Hospitalizations, Surgery, X-Ray and Special Studies

What hospitals, surgeries, x-rays or special studies have you had?

_____ year: _____ _____ year: _____
_____ year: _____ _____ year: _____
_____ year: _____ _____ year: _____
_____ year: _____ _____ year: _____
_____ year: _____ _____ year: _____

Allergies

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

_____

_____

_____

_____

_____

_____

Name:_____ Date:_____

Review of Symptoms

Answer questions or check any of the following you have or have had in the past 6 months.

GENERAL

Weight_____ Height_____ Weight 1 year ago_____lbs
Maximum(non pregnant weight_____ When?_____

LIFESTYLE HABITS:

Main Interests and hobbies?

_____

_____ Exercise, what kind _____
How often do you exercise? _____
_____ Y _____ N Have a religious/spiritual practice
_____ Y _____ N Average 6-8 hours of sleep
_____ Y _____ N Have a supportive relationship
_____ Y _____ N History of abuse
_____ Y _____ N Major Traumas
_____ Y _____ N Use of recreational drugs
_____ Y _____ N Treated for drug dependence
_____ Y _____ N Drink coffee
_____ Y _____ N Drink black or green tea
_____ Y _____ N Drink cola or other sodas
_____ Y _____ N Add salt to your food
_____ Y _____ N Eat refined sugar
_____ Y _____ N Enjoy your work
_____ Y _____ N Take vacations
_____ Y _____ N Spend time outside
_____ Y _____ N Watch TV?
How much _____
_____ Y _____ N Read?
How often_____
_____ Y _____ N Use alcoholic beverages
per week _____
_____ Y _____ N Treated for alcoholism
_____ Y _____ N Use tobacco currently
_____ Y _____ N Use tobacco in the past
How many years? _____
How many packs per day? _____

Please shade in areas where you are experiencing pain on figures (if applicable).