Health Maintenance Exam Questionaire

If you are an established patient with this practice, you may skip the first page.

Please list any allergies to any medication and what happens when you take the medication:

Please list current medications. If possible, include dosages and how often you take the medication.

Please list any medical problems for which you are currently being treated:

Please list any major medical issues for which you have been treated in the past:

Please list any previous surgeries and the year the surgery occurred:

Please indicate if anyone in your family has been diagnosed with the following medical conditions:
[ ] Alcoholism/substance abuse
[ ] Diabetes
[ ] High blood pressure
[ ] Heart failure
[ ] Heart attack
[ ] Stroke
[ ] Skin cancer
[ ] Colon cancer
[ ] Other

Do you have any other concerns you would like to discuss today?

Please indicate if you have had any of the following symptoms during the last month:

[] fever	[] lightheadedness/dizziness	[] fainting
[] cough	[] shortness of breath	[] chest pain
[] swelling	[] diarrhea/abnormal stools	[] abnormal discharge
[] pain with urination	[] excessive urination	[] excessive thirst
[] vision changes	[] skin changes	[] other:

Please indicate if you have received the following immunizations:

[ ] Influenza vaccine within the past year [ ] Tetanus vaccine within the past 10 years
[ ] Chicken pox vaccine [ ] HPV vaccine
[ ] Measles/mumps/rubella (MMR) vaccine [ ] Zoster (shingles) vaccine
[ ] Pneumococcal pneumonia vaccine

In the past two weeks, how often have you felt down, depressed, or hopeless:
[ ] Not at all [ ] Some of the days [ ] More than half of the days [ ] Nearly every day

In the past two weeks, how often have you had little interest or pleasure in doing things:
[ ] Not at all [ ] Some of the days [ ] More than half of the days [ ] Nearly every day

On average, how many alcoholic beverages do you drink per week? ______

Have you had 5 more drinks on one occasion in the past month? Yes No

Do you currently use tobacco products? Yes No

If you have ever smoked, please indicate:
Total number of years you have smoked: ______
Average number of packs per day smoked: ______

Do you use recreational drugs? Yes No
Have you ever injected recreational drugs? Yes No

Number of sexual partner(s) within the past year: ______

Please indicate whether your sexual partner(s) have been: Male Female Both N/A

Have you ever been tested for HIV? Yes No
Have you ever tested positive for HIV? Yes No
Would you like to be tested for HIV today? Yes No

Please indicate if you have ever been diagnosed with and/or treated for a sexually transmitted infection other than HIV:

Does your diet include recommended amounts of fruits and vegetables? Yes No Unsure

Are you interested in further nutritional counseling? Yes No Unsure

Do you use sunscreen? Yes No

Please complete if you are 35 years of age or older:

Have you ever been diagnosed with diabetes? Yes (Type 1) Yes (Type 2) No

Has anyone in your family been diagnosed with diabetes? Yes (Type 1) Yes (Type 2) No

Have your cholesterol levels ever been tested? Yes No

Please indicate if you have any of the following medical conditions:
[ ] High blood pressure
[ ] High cholesterol

Has anyone in your family been diagnosed with colon cancer before age 60? Yes No

Please complete the following if you are 50 years of age or older:

Do you take aspirin? Yes No

Have you ever been diagnosed with gastrointestinal bleeding? Yes No

Have you ever been diagnosed with colon cancer? Yes No
Has anyone in your family ever been diagnosed with colon cancer? Yes No
Have you had a colonoscopy within the past 10 years? Yes No
Have you had fecal occult blood testing within the past year? Yes No

Please complete if you are 65 years of age or older:

Have you been injured during a fall within the past year? Yes No

Have you ever been screened for an abdominal aortic aneurysm? Yes No

Women's Health

Do you feel safe at home? Yes No

Are you currently pregnant? Yes No Unsure

Have you had a Pap exam within the past three years? Yes No

Have you ever had an abnormal Pap result? Yes No

Have you ever been diagnosed with breast cancer? Yes No

Has a family member ever been diagnosed with breast cancer? Yes No

Has a family member ever been diagnosed with ovarian cancer? Yes No

Have you or anyone in your family been tested for the BRCA gene? Yes No

Please complete if you are 40 years of age or older:

Have you had a mammogram within the previous two years? Yes No

Please complete if you are 65 years of age or older:

Have you ever been screened for osteoporosis? Yes No