

Patient First/Last Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Today's Date: \_\_\_\_\_ Doctor: \_\_\_\_\_

## **HEALTH SCREEN QUESTIONNAIRE**

Thank you for taking the time to answer these few questions below. Please answer to the best of your ability. Exact date is not needed month and year is acceptable. This information is vital to your health.

### **ALL PATIENTS AGE 50 AND OLDER**

1. Have you ever had a screening colonoscopy? \_\_\_\_\_ If yes, where? \_\_\_\_\_  
Who was the doctor? \_\_\_\_\_
2. Have you completed stool cards that screen for blood? \_\_\_\_\_ Where? \_\_\_\_\_

### **DIABETIC PATIENTS**

1. When was your last fasting blood test? \_\_\_\_\_ Where? \_\_\_\_\_
2. When was your last diabetic urine test? (microalbumin) \_\_\_\_\_ Where?  
\_\_\_\_\_
3. When was your last foot exam with a podiatrist? \_\_\_\_\_ Where? \_\_\_\_\_
4. When was your last eye exam? \_\_\_\_\_ Where? \_\_\_\_\_

### **FEMALE PATIENTS**

1. When was your last mammogram? \_\_\_\_\_
2. When was your last pap smear? \_\_\_\_\_ Who performed the  
exam? \_\_\_\_\_ Where? \_\_\_\_\_
3. Have you ever had a chlamydia screen test? (ages 16-25) \_\_\_\_\_ If  
yes, when? \_\_\_\_\_ Where? \_\_\_\_\_

\*Staff Initials \_\_\_\_\_