Physical Exam Questionnaire

NAME: ______________________ DOB: __________ DATE: ____________

Medications:

Please list any CHANGES or NEW medications: ______________________

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Medication Allergies (including type of reaction): ______________________

Please provide most recent date for the following:

Mammogram: ______________

Pap smear: ______________

DEXA/Bone density: ______________

LMP: ______________

Colonoscopy/Cologuard: ______________

Pneumonia vaccine: ______________

Tetanus: ______________

Shingles vaccine: ______________

Depression Screening	**Not at all**	**Several days**	**More than half the days**	**Nearly all the days**
Over the past 2 weeks, how often have you felt little interest or pleasure in doing things?				
Over the past 2 weeks, how often have you felt down, depressed, or hopeless?				

Family History:

Heart Disease: ______________________

Diabetes: ______________________

Cancer/Type: ______________________

Social History:

Alcohol Use: No ___ Yes___ Number of drinks per week:____ Type of alcohol:______________

Drug Use: No ___ Yes___ Past___ Frequency:__________ Type:______________

Tobacco Use: No___ Yes___ Past ___ Quit date: __________ Packs per day__________

Number of years smoked: ______________

Surgical History: ______________________

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Concerns for today? ______________________

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