Preventative Health Evaluation

Patient Name: _____ **DOB:** _____ **Date:** _____

1. What specialist do you see:
   a. Dentist: _____
   b. Ophthalmologist: _____
   c. Other: _____
2. What activities of daily living are difficult for you (please circle):

Yard work	House work	Driving	Finances
Medical Decisions	Meal Prep	Eating	Dressing
	Bathing	Toilet	

3. Which of the following best describes your choices for “End of Life” planning (please circle)?
   a. I want Full Resuscitation
   b. I do not want Full Resuscitation
   c. I want Life Support Measures
   d. I want no Life Support Measures
   e. Life Support Measures are OK as long as there is hope of recovery.
4. Who is your health care representative / emergency contact: _____
5. Can you provide us with an Advanced Directive to Physicians? Yes No
6. IMMUNIZATIONS: (When traveling to foreign countries, let us know so we can advise you about any other vaccines or medications that may be needed.
   a. Last tetanus: _____ b. Last Influenza: _____
   c. Last Pneumonia:_____ d. Last Shingles: _____
7. Can you give us a copy of your immunization record: Yes No
8. SCREENING TEST:
   a. Last Colonoscopy was: _____ by:_____ results: _____
   b. Last chest x-ray was: _____ results: _____
   c. Last EKG was: _____ results: _____
   d. Last preventive health lab was: _____
   e. (For Men) Last PSA was: _____
   f. (For Men) Last Prostate Exam was: _____
   g. (For Women) Last PAP Smear was: _____ results: _____
   h. (For Women) Last Mammogram: was: _____ results: _____
   i. (For Women) Last Dexa/bone density scan: was: _____ results: _____

9. Do you do self breast exams: Yes No

10. Do you want a hearing test: Yes No

11. How often do you exercise (circle one): daily 3x/wk 5x/wk never rarely

12. What type of exercise do you like: _____

13. How many hours of sleep do you usually get each night: _____

14. How many cups of water is enough for you to drink daily: _____

15. Do you engage in any uncontrolled habits such as:
    a. Tobacco: _____ cig per day or
       _____ can per week
    b. Alcohol: _____ drinks per week
    c. Recreational drug: _____
    d. Controlled substances: _____
    e. Gambling: _____ times per month