Today's Date: ______________
Patient Name: ____________________________________
DOB: ______________

Preventive Health Questionnaire, Age 21 and Older

Please complete (mark the appropriate box) this Preventive Health Questionnaire. Your healthcare provider uses it as a tool for a part of your well exam. Feel free to discuss questions if you are unsure of your answer. This form will be returned to you after your exam.

Today's Visit

Are there any specific concerns you would like to discuss with your provider? ☐ Yes ☐ No

- **If YES**, list your concerns:

Health and Wellness

Question		
1) How often do you eat a well-balanced diet? A well-balanced diet includes selections from each of these groups:		
a) Fruits & vegetables	☐ Every day ☐ Most days	☐ Some days ☐ Rarely or Never
b) Bread/cereal/rice/pasta	☐ Every day ☐ Most days	☐ Some days ☐ Rarely or Never
c) Milk/yogurt/cheese	☐ Every day ☐ Most days	☐ Some days ☐ Rarely or Never
d) Meat/poultry/fish/dry beans	☐ Every day ☐ Most days	☐ Some days ☐ Rarely or Never
2) Do you use caffeinated beverages?	☐ No	☐ Yes ___ cups or cans per day
3) How often do you read food labels (nutrition facts) to make decisions about the food you eat?	☐ Always ☐ Sometimes	☐ Never
4) On average, how many times per day do you eat a serving of high fat foods such as: red meats; fried foods; whole milk; regular cheese; ice cream; baked goods; or regular salad dressings?	☐ 0-2 times per day	☐ 3 or more times per day
5) Do you take Vitamin D?	☐ Yes	☐ No ☐ I don't know
6) Considering a 7 day period, how often did you spend at least 30 minutes a day doing activities such as walking, biking or gardening?	☐ 4 or more days per week	☐ 1- 3 days per week ☐ 0 days per week
7) Considering a 7 day period, how many times on the average do you do strenuous exercise (heart beats rapidly) for more than 15 minutes?	☐ 4 or more times per week	☐ 1- 3 days per week ☐ 0 days per week
8) Did you have a drink containing alcohol in the past year?	☐ No	☐ Yes
9) How often do you use drugs such as marijuana, cocaine, speed, LSD, heroin, prescription drugs that are not yours, etc?	☐ Never	☐ Daily ☐ Weekly ☐ Rarely
10) Do you have a Health Care Directive (a document that describes how you would like health care decisions made for you if you should become unable to make the decisions yourself?)	☐ Yes	☐ No
11) Do you receive care from a dentist on a yearly basis?	☐ Yes	☐ No
12) Do you see an eye doctor at least every 2 years?	☐ Yes	☐ No
13) How often do you feel you are under a lot of stress?	☐ Never ☐ Sometimes	☐ Most of the time ☐ Always
14) Have you or any family members (parents, siblings, or children) had colon cancer or colon polyps? • **If YES**, or you are over 50, have you ever had a colon cancer screening test (Colonoscopy, Flexible sigmoidoscopy, Cologuard or iFOBT test?)	☐ No ☐ I don't know	☐ Yes ☐ Colonoscopy ☐ Flexible sigmoidoscopy ☐ Cologuard ☐ iFOBT test

Health and Wellness		
15) If you are sexually active, are you in a mutually monogamous relationship? (Do you and your partner only have sex with each other?)	☐ I am not sexually active ☐ Yes	☐ No ☐ I don't know
16) Have you or your partner had more than one sexual partner in the past year?	☐ No	☐ Yes
17) Do you have any of the following risks for HIV, AIDS, Hepatitis B or Hepatitis C?		
1) Recent treatment for sexually transmitted diseases	☐ No	☐ Yes
2) You are a man and have had a male sexual partner after 1975	☐ No	☐ Yes
3) You or a partner have any history of illegal injectable/intranasal drug use	☐ No	☐ Yes
4) You or a partner have had sex for money (prostitution)	☐ No	☐ Yes
5) You have a past or present partner with HIV	☐ No	☐ Yes
6) You have had a blood transfusion between 1978 and 1985	☐ No	☐ Yes
7) You have a past or present partner who is bisexual	☐ No	☐ Yes
8) Were you born between 1945 and 1965?	☐ No	☐ Yes
18) Do you take steps to avoid unwanted pregnancy?	☐ Always	☐ Sometimes ☐ Rarely or Never
19) Being involved in an abusive relationship, or having been previously abused, can seriously affect a person's physical and emotional health. In the past year, have any of the following happened to you?		
1) Physical/sexual abuse (hitting, slapping, choking, forced sex)	☐ No	☐ Yes
2) Verbal/emotional abuse (threats, intimidation, controlling through fear, insults)	☐ No	☐ Yes
20) <u>WOMEN ONLY</u>**:** Have you ever had an abnormal pap test?	☐ No	☐ Yes ☐ Uncertain
Safety		
21) How often do you wear a seat belt when driving or riding in a vehicle?	☐ Always	☐ Sometimes ☐ Never
22) How often do you wear a helmet when participating in any of these activities: motorcycle, bicycle, snowmobile, skiing, snowboarding, inline skating, all terrain vehicles or horseback riding?	☐ I don't do any of these activities ☐ Always	☐ Sometimes ☐ Never
23) Do you have a working smoke detector in your home?	☐ Yes	☐ No ☐ Don't know
24) Do you use sunblock at SPF 30 or greater to protect skin from the sun?	☐ Always ☐ Most of the time	☐ Sometimes ☐ Rarely or Never
25) How often do you drive or ride in a motor vehicle when the driver (you or someone else) has been using alcohol or drugs?	☐ Never	☐ Often ☐ Sometimes ☐ Rarely
26) Is your water heater set (at or below 120˚F) so that no one can be burned?	☐ Yes	☐ No ☐ Don't know
27) Are potentially poisonous items in your home locked and stored where children cannot get at them?	☐ Never any children in my home ☐ Yes	☐ No
28) Do you have firearms or other weapons in your home?	☐ Yes ☐ No	
• **If YES**, are firearms locked and stored unloaded?	☐ Yes	☐ No
29) Falls are a serious health risk:		
a) Do all the stairs in your home have handrails and traction strips?	☐ Yes	☐ No
b) Are all your sidewalks and driveways evenly paved?	☐ Yes	☐ No
c) Does your bathtub have a handrail or traction strips?	☐ Yes	☐ No
d) Have you removed any loose rugs or clutter from your floors?	☐ Yes	☐ No