Do not write, stamp, punch holes or affix a sticker in this area. To reproduce, follow the printing instructions. Do not fold this form.

Direction of Feed

Preventive Health

Please answer every question

STAFF: *Handwritten items must be entered* ***MANUALLY***.

Marking Instructions

Please use a # 2 pencil
Fill in the complete oval as shown...

PLEASE PRINT PATIENT'S LAST NAME

PLEASE PRINT PATIENT'S FIRST NAME

PATIENT'S DATE OF BIRTH

Month Day Year

THIS SECTION IS FOR MALES AND FEMALES

				If "yes" please list approximate date
Have you ever had any of the listed colon cancer screenings?				
Colonoscopy	○ yes	○ no	○ do not know	___/___/____
Sigmoidoscopy	○ yes	○ no	○ do not know	___/___/____
Barium enema	○ yes	○ no	○ do not know	___/___/____
Stool hemocult (test for blood in stool)	○ yes	○ no	○ do not know	___/___/____
Have you been immunized against the following				
Human papillomaviruses (HPV) (Guardasil)	○ yes	○ no	○ do not know	___/___/____
Influenza (Flu) within the past year	○ yes	○ no	○ do not know	___/___/____
Measles, Mumps & Rubella (MMR)	○ yes	○ no	○ do not know	___/___/____
Pneumonia	○ yes	○ no	○ do not know	___/___/____
Shingles (Zostavax)	○ yes	○ no	○ do not know	___/___/____
Tetanus / Diphtheria (within last 10 years)	○ yes	○ no	○ do not know	___/___/____
Chickenpox (Varicella)	○ yes	○ no	○ do not know	___/___/____
Have you had your cholesterol checked in the last five years?				
	○ yes	○ no	○ do not know	___/___/____

*** MALES ONLY ***

				If "yes" please list approximate date
Have you had the following?				
Prostate cancer screening (age 40+)	○ yes	○ no	○ N/A	___/___/____
Any problems with sexual activity?	○ yes	○ no	○ N/A	
Do you perform monthly self-testicular exams?	○ yes	○ no	○ N/A	

*** FEMALES ONLY ***

				If "yes" please list approximate date
Have you had the following?				
Test for chlamydia (age 24 and under)	○ yes	○ no	○ N/A	___/___/____
Pap smear within the past 2 years (age 18+)	○ yes	○ no	○ N/A	___/___/____
Have you had an abnormal pap smear?	○ yes	○ no	○ N/A	___/___/____
Mammogram within the past 2 years (age 40+)	○ yes	○ no	○ N/A	___/___/____
Bone density study / dexa scan within the past 2 years (age 50+)	○ yes	○ no	○ N/A	___/___/____
Please write in the ending date of your last menstrual period				___/___/____
Are you pregnant or possibly pregnant?	○ yes	○ no	○ N/A	
Have you had any problems with sexual activity?	○ yes	○ no	○ N/A	
Do you perform monthly self-breast exams?	○ yes	○ no	○ N/A	
Do you take a daily calcium supplement?	○ yes	○ no	○ N/A	
Are you currently using birth control?	○ yes	○ no	○ N/A	

If yes, what method? ○ abstinence ○ intra-uterine device (IUD) ○ rhythm method ○ condom ○ pill / injection / patch / ring ○ surgical sterilization ○ other

Age at onset of menstruation?

N/A	Less than 8	8	9	10	11	12	13	14	15	16	17	18	19	20	21+
○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○

Age at onset of menopause?

N/A	Less than 42	42	43	44	45	46	47	48	49	50	51	52	53	54	55+
○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○

Pregnancy history

	0	1	2	3	4	5	6	7+
Number of pregnancies	○	○	○	○	○	○	○	○
Number born alive	○	○	○	○	○	○	○	○
Number of stillbirths	○	○	○	○	○	○	○	○
Number of premature births	○	○	○	○	○	○	○	○
Number of miscarriages	○	○	○	○	○	○	○	○
Number of abortions	○	○	○	○	○	○	○	○
Number of caesarean births	○	○	○	○	○	○	○	○

For technical support, please contact PatientLink at ***Support@MyPatientLink.com.***