satellitemed

Employee Use:
"Screening Form"
Scanned_____
Date_____

Routine Physical Exam Patient Questionnaire

Patient Name: _____ **Date of Birth**: _____ **Today's Date**:_____

Concerns Today? _____

Do you need refills? If so, list: _____

1) Date of last **Physical Exam**: _____ Provider: _____
Were labs completed? *(CMP, CBC, PSA, Thyroid, A1c, Lipids)* **Yes / No**
Are you diabetic? **Yes / No**
Did you have a skin/mole exam? **Yes / No**
Have you had a rectal or prostate exam? **Yes / No**

2) Last **Colonoscopy**: _____ Where:_____
Was it Normal? **Yes / No** *(explain)* _____

3) Do you wear Contacts or Glasses? **Yes / No** Date of last exam:_____

4) Date of last Dental Exam: _____ Provider:_____ Where:_____

5) Tobacco Use? **Yes / No** **What kind?** _____
Amount/day?_____ # of Years_____ Quit?_____ When?_____

6) Do you drink alcohol? **Yes / No**
If Yes, Drinks/day?_____ per week?_____ Quit?_____ When?_____

7) Do you exercise regularly? **Yes / No**
If Yes, Minutes/day?_____ per week?_____ Type: Cardio / Strength / Other:_____

8) Do you follow a specific diet? **Yes / No**
If Yes, please list_____

9) Are you sexually active? **Yes / No**
Number of current sexual partners: _____ **Male / Female** (circle all that apply)

Women Only

10) Last **Pap Smear**: _____
Was it Normal? **Yes / No** *(explain)* _____

11) Last **Mammogram**: _____ Where:_____
Was it Normal **Yes / No** *(explain)* _____

12) Total Number of Pregnancies: _____ Term:_____ Preterm:_____

Abort/Miscarr: _____ Living children:_____
(office use only) G_____T_____P_____A_____L_____

13) **Last Menstrual Cycle**: _____
Cycles Typically Occur every _____ Days and last _____ Days
Age Menstruation started _____ yrs
Age Menopause started _____ yrs

14) GYN surgeries/procedures: _____