NAME:______________________________ DOB______________

Medical Group is in the process of converting into an electronic medical health record. We anticipate that this will improve the quality of care that we can deliver, as well as assist in care at outside providers such as specialists and hospitals. Please help us to ensure that your record is accurate and complete by completing the following questionnaire.

Have you had any of the following tests or procedures? If so please estimate the dates.

Colonoscopy ______________________

Pulmonary function tests (breathing test) ______________________

Glaucoma screening and eye exam ______________________

Bone Density test ______________________

PSA (blood test for prostate) ______________________

PAP smear ______________________

Mammogram ______________________

Flu shot ______________________

Pneumonia shot ______________________

Shingles shot ______________________

Tetanus and/or pertussis shot ______________________

Hepatitis A vaccine ______________________

Hepatitis B vaccine ______________________

Chicken pox disease ______________________

Chicken pox vaccine ______________________

Do you smoke? ______________________

If so, how much? ______________________

If not, did you smoke in the past? ______________________

Do you drink alcohol? ______________________

If so, amount and how often? ______________________