Preventive Health Questionnaire, Age 21 and Over

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.

1. Are there any specific concerns you would like to discuss with your physician?

2. Do you use caffeinated beverages?	No		Yes ____Cups or cans per day	
3. How often do you eat a well-balanced diet? A well-balanced diet includes selections from each of these groups: • Fruits and vegetables; • Milk/yogurt/cheese; and • Bread/cereal/rice/pasta; • Meat/poultry/fish/dry beans	Every day	Most days	Some days	Rarely or never
4. How often do you read food labels (nutrition facts) to make decisions about the food you eat?	Always	Sometimes	Never	
5. 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; Regular salad dressings?	0-2 times/day		3 or more times/day	
6. On how many of the past 7 days did you spend at least 30 minutes a day doing activities such as walking, biking, or gardening?	4 or more days/week		1-3 days/week	0 days/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 days/week		1-3 days/week	0 days/week
8. How often do you wear a seat belt when driving or riding in a car?	Always		Sometimes	Often
9. How often do you wear a helmet when participating in any of these activities: motorcycle, bicycle, snowmobile, skiing, snow boarding, inline skating all terrain vehicles or horseback riding?	I don't do any of these activities	Always	Sometimes	Never
10. 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	I don't know	No
11. Have you or your partner had more than one sexual partner in the past year?	No		Yes	
12. Do you have <u>any</u> of the following risks for HIV, AIDS, Hepatitis B or Hepatitis C? • Recent treatment for sexually transmitted diseases • You are a man and have had a male sexual partner after 1975 • You or a partner have any history of illegal injectable/intranasal drug use • You or a partner have had sex for money (prostitution) • You have a past or present partner with HIV • You have had a blood transfusion between 1978 and 1985 • You have a past or present partner who is bisexual • You have had multiple sexual partners in the past	No		I don't know	Yes
13. Do you take steps to avoid unwanted pregnancy?	Always		Sometimes	Rarely or Never
14. 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? • Physical/sexual abuse (hitting, slapping, choking, forced sex) • Verbal/emotional abuse (threats, intimidation, controlling through fear, insults)	No		Yes	

15. How often do you feel you are under a lot of stress?	Never	Sometimes	Most of the Time	Always
16. Have you or any family members (parents, siblings, or children) had colon cancer or colon polyps?	No		Don't know	Yes
17. If you answered "yes" to question 16, or are over 50, have you ever had a colon cancer screening test (Flexible sigmoidoscopy, proctological exam, barium enema, checking stool for blood, colonoscopy)?	Flex sig/Procto:_____ Barium enema:_____ Stool cards for blood:_____ Colonoscopy :_____		Don't know	No
18. Do you use sun block at SPF 15 or greater to protect skin from the sun?	Always	Most of the Time	Sometimes	Rarely or Never
19. How often do you have two or more drinks (daily) containing alcohol?	Rarely	Never	Weekly	Daily
20. How often do you use drugs such as marijuana, cocaine, speed, LSD, heroin, etc.?	Never		Rarely	Weekly / Daily
21. How often do you drive or ride in a motor vehicle when the driver (you or some one else) has been using alcohol or drugs	Never		Rarely	Sometimes / Often
22. 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	
23. Do you receive care from a dentist on a yearly basis?	Yes		No	
24. Do you see an eye doctor at least every 2 years?	Yes		No	
25. Do you have a working smoke detector in your home?	Yes		Don't Know	No
26. Are potentially poisonous items in your home locked and stored where children cannot get at them?	Never any children in my home	Yes	No	
27. Is your water heater set so that no one can be burned (at or below 120°F)?	Yes		Don't Know	No
28. Do you have firearms or other weapons in your home?	No		Yes	
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	
WOMEN ONLY ANSWER QUESTIONS BELOW				
30. How often are you using birth control (such as birth control pills, condoms or diaphragms, ring or patch or Depo-Provera)?	Does not apply	Always	Sometimes	Never
31. Have you had a hysterectomy?	No		Yes, for cancer	Yes, for a reason other than cancer
32. When starting Pap smear screening, it's important to have 3 normal Pap smears in a row. Have you had 3 normal Pap smears in a row within any 5-year period?	Yes		Don't Know	No
33. Do you practice self-breast examination once a month?	Always		Sometimes	Rarely or Never
34. Are you planning a pregnancy or at risk for becoming pregnant?	No		Uncertain	Yes