Ami Laws, MD
Health Screening Questionaire

Name: _____ Date of Birth:_____

Please list your current medical problems:

_____
_____
_____
_____
_____
_____

Please list your medications including birth control pills and vitamins:

_____
_____
_____
_____
_____

List any <u>ALLERGIES</u> to medications:

_____
_____

<u>Immunizations:</u> **<u>Dates:</u>**

Last TDAP or TD booster (approximate): _____
Pneumovax: _____
Prevnar: _____
Shingles Vaccine: _____

<u>WOMEN ONLY:</u>

Are your periods regular (circle)? Yes No

Menopausal Hysterectomy

Year of last Pap: _____

Have you ever had an abnormal Pap (circle)?

Yes No Year: _____

Have you ever been pregnant (circle)?
Yes No

If yes, # of children: _____
# of miscarriages: _____
# of abortions: _____

Have you ever had a mammogram?
Years (s): _____, _____, _____

<u>Men & Women:</u>
Please list any major surgeries you have had and the year you had them:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Year of last Screening for Sigmoidoscopy or Colonoscopy? _____

<u>Health Habits & Screening ?</u>

Do you smoke(circle one)?
Yes No

Drink Alcohol (circle)? None
Rarely
Daily Weekly

Exercise regularly? Yes No

Cholesterol checked within last 5 years? Yes No

<u>Family Medical History:</u>

Diabetes? Yes No

Heart Attacks? Yes No

High Blood Pressure? Yes No

Breast Cancer? Yes No

Prostate Cancer? Yes No

Colon Cancer? Yes No

<u>Your Concerns Today:</u>

_____
_____
_____
_____
_____

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