TREASURE COAST
Primary Care

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PREVENTATIVE MEDICAL QUESTIONNAIRE

PATIENT AUTHORIZATION AND NOTICE

____ ____________

Patient Name Date of Birth

ANSWER THE QUESTIONS AS ACCURATELY AS POSSIBLE
Please help us keep your chart up to date by letting us know which of the following you have had and the dates. If you are not sure of the date, please give an estimate. **If a question is not clear, please ask one of our staff to explain it.**

MEDICAL EXAMS/TESTS:

Colonoscopy	☐ YES	☐ NO	☐ NORMAL	☐ ABNORMAL	DATE: __________
Endoscopy	☐ YES	☐ NO	☐ NORMAL	☐ ABNORMAL	DATE: __________
Exercise Stress Test	☐ YES	☐ NO	☐ NORMAL	☐ ABNORMAL	DATE: __________
Nuclear Stress Test	☐ YES	☐ NO	☐ NORMAL	☐ ABNORMAL	DATE: __________
Stress Echo	☐ YES	☐ NO	☐ NORMAL	☐ ABNORMAL	DATE: __________
Echocardiogram	☐ YES	☐ NO	☐ NORMAL	☐ ABNORMAL	DATE: __________
Carotid Doppler	☐ YES	☐ NO	☐ NORMAL	☐ ABNORMAL	DATE: __________
Aortic Ultrasound	☐ YES	☐ NO	☐ NORMAL	☐ ABNORMAL	DATE: __________
Bone Density Scan	☐ YES	☐ NO	☐ NORMAL	☐ ABNORMAL	DATE: __________
Mammogram	☐ YES	☐ NO	☐ NORMAL	☐ ABNORMAL	DATE: __________
Pap Smear	☐ YES	☐ NO	☐ NORMAL	☐ ABNORMAL	DATE: __________
Sleep Study	☐ YES	☐ NO	☐ NORMAL	☐ ABNORMAL	DATE: __________
Chest X-ray	☐ YES	☐ NO	☐ NORMAL	☐ ABNORMAL	DATE: __________
Dental Exam	☐ YES	☐ NO	☐ NORMAL	☐ ABNORMAL	DATE: __________
Eye Exam	☐ YES	☐ NO	☐ NORMAL	☐ ABNORMAL	DATE: __________
Dermatology Exam	☐ YES	☐ NO	☐ NORMAL	☐ ABNORMAL	DATE: __________
Urology Exam	☐ YES	☐ NO	☐ NORMAL	☐ ABNORMAL	DATE: __________
EKG	☐ YES	☐ NO			DATE: __________
Flu Shot	☐ YES	☐ NO			DATE: __________
Pneumonia Shot	☐ YES	☐ NO			DATE: __________
Tetanus Shot	☐ YES	☐ NO			DATE: __________
Shingles Vaccine	☐ YES	☐ NO			DATE: __________