PISGAH FAMILY HEALTH

Health Screening Checklist – ages 20 - 49

Name: _____ Date: _____ Age: _____

Medical Care

When was your last Physical Exam? _____ Eye Exam _____ Dental Exam _____

When was your last cholesterol test? _____ Result _____

Do you take a multivitamin? _____ Iron? _____ Other supplements? _____

How do you prevent pregnancy? _____ How do you prevent sexual infections? _____

Lifestyle

How much tobacco do you use? _____ Are you interested in quitting? _____

How often do you drink alcohol? _____ How many drinks do you usually consume? _____

How often do you exercise? _____ What do you do for exercise? _____

How often do you eat fast food? _____ How much weight do you need to lose? _____

Do you have a Living Will or Health Care Power of Attorney? □ Yes □ No
If yes - please be sure we have a copy on file. **If not** - please ask your doctor for information.

In the past 2 weeks, how often have you:	Never	Sometimes	More than half the time	Nearly every day
Had little interest or pleasure in doing things?	0	1	2	3
Felt down, depressed, or hopeless?	0	1	2	3
Felt unsafe in your home or workplace?	0	1	2	3

Vaccinations

Do you get the Flu Shot each Fall? _____ When was your last Tetanus Shot? _____

Women

When was your last pap smear? _____ Any abnormal results? _____

When was your last mammogram?_____ Any abnormal results? _____