**NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**DO YOU HAVE PREVENTATIVE CARE WITH YOUR INSURANCE?** YES OR NO

WHen was your last physical? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When was your last TETANUS? \_\_\_\_\_\_\_\_\_\_\_\_ When was your last COLONOSCOPY? \_\_\_\_\_\_\_\_\_

Do you have any of the following problems?

1. Change in size/color of a mole YES OR NO
2. Chest pain, shortness of breath, YES OR NO

stomach problems or heartburn

1. Sexual problems (getting and YES OR NO

keeping erections, completing

intercourse, etc.)

1. Sleeping poorly or having anY YES OR NO

trouble falling or staying asleep

1. Often feeling down, depressed or YES OR NO

Hopeless in the last month

1. Do you drink alcohol? YES OR NO
2. Have you ever used tobacco? YES OR NO

Please list any concerns YOU MAY have at this timE:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Were there any tests/labs you were interested in having ordered or done today? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**C:\Documents and Settings\mjorasz\Local Settings\Temporary Internet Files\Content.IE5\FMCQX3KW\MC900115855[1].gif**

**for physician use:**

Imunizations Preventative

Tdap Pneumovax Influenza Colonoscopy EKG Bone Density Stress Test



 CT Lung Screening AAA Screen

labs Studies

CBC CMP Lipid PSA Glucose TSH Chest X-Ray Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_