COMPREHENSIVE ASSESSMENT QUESTIONAIRE

For Established Patients

DATE_____

PATIENT NAME_____ BIRTHDATE_____

MEDICAL HISTORY (List any changes since past physical exam)

New diagnosis:_____

Surgeries:_____

Medicine allergies:_____

New Medications:_____

Vitamins/Herbs:_____

FAMILY HISTORY (List any changes since past physical exam)

	Age			
Mother		Alive	Deceased	Medical problems:_____
Father		Alive	Deceased	Medical problems:_____
Paternal GM		Alive	Deceased	Medical problems:_____
Paternal GF		Alive	Deceased	Medical problems:_____
Maternal GM		Alive	Deceased	Medical problems:_____
Maternal GF		Alive	Deceased	Medical problems:_____

Is there anyone in your family with:

Diabetes?	Yes	No
Heart attacks before age 55 in male or 65 in a female?	Yes	No
Strokes?	Yes	No
Colon Cancer?	Yes	No
Prostate Cancer?	Yes	No
Breast Cancer?	Yes	No
Other Female Cancers?	Yes	No

PREVENTATIVE TESTING

Have you had a Colonoscopy in the past 10 years?	Yes	No
Have you had a tetanus booster in the past 10 years?	Yes	No
Have you had an EKG in the past 5 years?	Yes	No
If older than 60, have you had a shingles shot?	Yes	No
If female over 50, had a bone density test in past 2 years?	Yes	No
If female over 45, mammogram in past year?	Yes	No
If male over 65 with history of smoking (previous or current)	Yes	No
Have you had an abdominal ultrasound?	Yes	No
Have you had an eye exam in the past year?	Yes	No
Have you had a dental exam in the past year?	Yes	No

PREVENTATIVE HABITS

Do you take a baby aspirin daily?	Yes	No
Do you exercise regularly?	Yes	No
Are you careful about what foods you eat?	Yes	No
Do you keep your alcohol intake less than 1-2 a day?	Yes	No