Female Preventive Questionnaire: Name _____

Do you get at least three servings of calcium containing foods daily (dairy, green leafy vegetables, etc.)?

❏ Yes

❏ No, I am taking Calcium C and/or Vitamin D supplement

❏ I am taking other multivitamins, and those are: _____

What amount of exercise or daily activities are you doing outside of work?

o Number of days per week _____ (fill in)

Problems taking medications regularly

❏ Yes, _____

❏ No

❏ Not applicable

Are you currently experiencing any medication side effects?

❏ Yes, _____

❏ No

Have you had an eye exam in the past two years?

❏ Yes

❏ No

Do you see a dentist twice per year?

❏ Yes

❏ No If not, how often?_____

Do you have sleep apnea, excessive snoring or daytime drowsiness? Please circle which condition you have, if any.

❏ Yes

❏ No

In the past two weeks, did you have little interest or pleasure in doing things?

❏ Not at all

❏ A few days

❏ More than half the days

❏ Nearly every day

In the past two weeks, did you feel down, depressed or hopeless?

❏ Not at all

❏ A few days

❏ More than half the days

❏ Nearly every day

What is your current smoking status?

❏ Never smoked

❏ Currently smoking

❏ Quit

Do you use smokeless tobacco?

Yes _____

No _____

I drink alcohol:

❏ I don't drink

❏ Less than 3 drinks a day

❏ I drink more than 3 drinks a day,

Have you currently or in the past, suffered physical, sexual or emotional abuse? Yes ____ No ____

My last mammo was _____ ***(date)*****, and was done at** _____ ***(location)***

My last pap was _____ ***(date)*** **and done at** _____ **.** **MEDICARE PATIENTS PLEASE ANSWER THE FOLLOWING:**

Do you have a recent Advance Care Directive?

❏ Yes If yes, do we have a copy?_____

❏ No

If you are 65 years or older have you:

❏ Fallen two or more times in the past year?

❏ Yes

❏ No

In the past year, have you had an injury due to a fall?

❏ Yes

❏ No

Other concerns?_____