Routine Health Maintenance

Please provide the dates of the following if applicable.

1. first day of last menstrual period: .... ____/____/____
2. last pap smear: .... ____/____/____
3. last mammogram: .... ____/____/____
4. last colonoscopy: .... ____/____/____
5. last bone-density scan: .... ____/____/____
6. last tetanus/pertussis (Td/TDap) vaccine: ____/____/____
7. last pneumovax (pneumonia vaccine): ..... ____/____/____
8. last influenza (flu) vaccine: .... ____/____/____
9. last gardasil (HPV): .... ____/____/____
10. last Zostovax (shingles vaccine): .... ____/____/____
11. last TB (tuberculosis) screening: .... ____/____/____

Pediatrics *(personal/delivery/pregnancy/health history)*

If the patient is under 18, please provide the following information as applicable.

Is the child yours by: □ birth □ adoption □ marriage *(e.g., stepchild)* □ Other: _____

Ethnic background: _____

Date & place of birth: _____

Delivered by: □ vaginal birth □ Caesarean section

How many weeks pregnant when delivered? _____ Birth weight: _____ Birth height: _____

Any medical problems during pregnancy? □ no □ yes: _____

Was your child breast-fed? □ no □ yes — For how long? _____

Any feeding or dietary problems? □ no □ yes: _____

Recreation/play/exercise: _____

Average hours of sleep per night: _____ Number and length of naps: _____

Who takes care of the child during the day? _____

Advanced Healthcare Directive/Living Will

□ I have executed an Advanced Healthcare Directive, Living Will, or Durable Power of Attorney.

□ I would like to fill out an Advanced Healthcare Directive.

□ I would like to talk about my options.

□ I do not wish to fill out an Advanced Healthcare Directive at this time.

Staff reviewed. *A copy of Advanced Healthcare Directive, Living Will, or Durable Power of Attorney was placed in chart, if applicable.*   **Staff initials:** _____ **Date:** ____/____/____

Spiritual Assessment *(optional)*

Do you believe in God or a higher power? □ yes □ no

Would you appreciate a prayer for: □ yourself □ family □ health □ other: _____

If yes, please specify when: □ during office hours □ while I am not present □ not at this time