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?

Number of days per week (fill in). ______

Do You have problems taking medications regularly?

○ No ○ Not applicable ○ Yes (list) ______________________________

Are you currently experiencing any medication side effects?

○ No ○ Yes (list) ______________________________

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

○ No ○ Yes

Do you see a dentist twice per year?

○ No ○ Yes If no then how often? ______

Do you have sleep apnea, excessive snoring or daytime drowsiness?

○ No ○ Yes

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?

○ No ○ Yes

I drink alcohol:

○ I don't drink ○ I drink less than 3 drinks a day ○ More than 3 drinks a day

Have you currently or in the past, suffered physical, sexual or emotional abuse?

○ No ○ Yes

My last mammo was (date) __________ , and was done at (location) ______________________________

My last pap was (date) __________ , and done at location) ______________________________

Do you have a recent Advance Care Directive?

○ No ○ Yes If yes, do we have a copy? ______

Other concerns? ______________________________

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