Premise Health.

Health Maintenance Questionnaire

Please complete the following by providing the date of completion of the various items listed below. Please provide the most exact date possible, but you may estimate, if needed. Please place check marks in the appropriate columns if you have had the item done (but do not know or cannot estimate the date), or have never had the item done. If you have an item scheduled, please enter the date scheduled.

Item	Date of Last	Done, Date Unknown	Never Done	Scheduled Date
Examinations				
Routine/Annual Physical Exam (not GYN)				
Well Woman/GYN Exam				
Breast Exam				
Prostate Exam				
Dental Exam				
Eye Exam				
Diabetic Foot Exam				
Diagnostic Tests				
Pap Smear				
Mammogram				
Breast Ultrasound				
Breast MRI				
Bone Density Test				
Fecal Occult Blood Test (for blood in stool)				
Colonoscopy				
Sigmoidoscopy				
EKG/ECG				
Echocardiogram (Heart Ultrasound)				
Cardiac Stress Test (treadmill)				
Spirometry (breathing test)				
Abdominal Ultrasound				
TB Skin Test				
Lab Tests				
Lipid Panel (cholesterol test)				
Fasting Glucose (blood sugar)				
Hemoglobin A1C Test				
Glucose Tolerance Test				
Prostate Specific Antigen (PSA) Test				
HIV (human immunodeficiency virus) Test				
Immunizations				
Tetanus/Diphtheria				
Tetanus/Diphtheria/Pertussis (whooping cough)				
Influenza (flu shot)				
Pneumococcal (pneumonia)				
Zoster (shingles)				
HPV (human papilloma virus)				
Other:				