DUBLIN PRIMARY CARE

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Colorado Springs, CO 80918
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Preventative Medicine Screening Questionnaire

Please indicate you have had the following procedures done:

- ☐ Colonoscopy
  Date and Location Procedure was performed _____
  Results were **Normal** or **Abnormal** (Please Circle One)

- ☐ Dexa Scan
  Date and Location Procedure was performed _____
  Results were **Normal** or **Abnormal** (Please Circle One)

- ☐ Mammogram
  Date and Location Procedure was performed _____
  Results were **Normal** or **Abnormal** (Please Circle One)

- ☐ Pap Smear
  Date and Location Procedure was performed _____
  Results were **Normal** or **Abnormal** (Please Circle One)

- ☐ Cholesterol Screening
  Date and Location Procedure was performed _____
  Results were **Normal** or **Abnormal** (Please Circle One)

Are you Diabetic? ☐ YES ☐ NO
Date of last Diabetic Eye Exam: _____ Physician that performed Exam: _____
Results were **Normal** or **Abnormal** (Please Circle One)

Are you a Tobacco User? ☐ YES ☐ NO

If yes, how many cigarettes per day do you smoke, or other daily tobacco use: _____

If no, were you a former tobacco user? If so please list your quit date: _____

_____ _____
Patient Printed Name Date

_____ _____
Signature of Patient Patient Date of Birth
(Or Guardian/Guarantor if patient is a minor)