

Georgia Kidney Associates

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Preventative Health Questionnaire

Patient Name: _____ Date: _____

Please indicate the last time you had the following preventative health exams and/or immunizations:

All Patients

	Date
Colonoscopy	_____
Sigmoidoscopy	_____
Cholesterol Screening	_____

If Diabetic:

	Date
Vision Screening	_____
Podiatry (Foot) Exam	_____
Hemoglobin A1C	_____

If Male:

PSA	_____
Prostate Exam	_____

If Female:

Mammogram	_____
Breast Exam	_____
PAP Smear	_____

Adult Immunizations

Tetanus	_____
Influenza	_____
Pneumonia	_____
Hepatitis A	_____
Hepatitis B	_____

Childhood Immunizations (check Yes or No)

Mumps	Y <input type="checkbox"/> N <input type="checkbox"/>	_____
Measles	Y <input type="checkbox"/> N <input type="checkbox"/>	_____
Rubella	Y <input type="checkbox"/> N <input type="checkbox"/>	_____
Chicken Pox	Y <input type="checkbox"/> N <input type="checkbox"/>	_____