PACIFIC FAMILY MEDICINE

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Annual Health Evaluation Form

Name: ____________________________________ Date of Birth: ___________Date: _________
(Please Print)

Current List of Medications/Dose (including vitamins) Do you need a refill?

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Over the past 2 weeks, how often have you been bothered by any of the following problems?	**Not at all**	**Several Days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3

Please Answer The Following Questions:

Any Recent Surgery? _____Yes _____No

Any New Medication Allergies? _____Yes _____No

Do You Smoke? ___Yes ___No If yes, how many packs/day? ____. How long? ____

Do You Drink Alcohol? ___Yes ___No If yes, How many drinks per day?____week?____

Do You Exercise? ____Yes ____No If yes, How may days per week? ________

How many fruits/vegetables do you eat per day? ____/Day (recommended 5 per day)

Do you wear sunscreen? ____Yes ____No

Do you do monthly skin exams? ____Yes ____No

WOMEN: Do You Perform Self Breast Exams? ____ Yes ____ No

MEN: Do You Perform Self Testicular Exams? ____Yes ____No