PATIENT MEDICAL QUESTIONAIRE

Have you ever had a Colonoscopy? _____YES _____NO
If so, when?_____

(Females)
Have you ever had a Mammogram? _____YES _____NO
If so, when ?_____

Have you ever had a Bone Density Study? _____YES ____ NO
If so, when? _____

Have you ever had a Pneumovax Vaccine(for Pneumonia)? ____YES ____NO
If so, when? _____

Please list all current medications:

_____
_____
_____
_____
_____
_____
_____

Allergies:_____
_____

Please provide a pharmacy that you may use:

Pharmacy_____
Address_____City_____
Phone number_____

My preferred method of contact from Dr. Riddick's office is:

____Phone ____E-mail ____Postal Mail

Signed_____Date_____