Preventive Care Questionnaire-Medicare

Patient Name___________________

Date____________ **Age** ______

- Have you had a pneumonia vaccine?
  - Yes ___ No ___
  - If yes, what year? ________
- Have you had a herpes zoster, or shingles, vaccine?
  - Yes ___ No___
- When was your last flu vaccine?
  - Month/Year : ____________
- When was your last tetanus vaccine?
  - Year : _____________
- When was your last colonoscopy?
  - Year : __________
  - Do you have family history of colon cancer ? _______
- Have you had a cardiac screening (EKG, stress test, or other testing)?
  - Year : __________
  - Do you have family history of heart disease or stroke? Yes _____ No _____
  - Do you have family history of aortic aneurysm? Yes _____ No _____
- Have you had a dilated eye exam?
  - Yes ______ No ______
  - If yes, has it been less than 12 months ago? _______
- Have you had fasting lab done in the last 3 years? Yes ______ No ______
- Do you take a multivitamin? Yes ______ No ______
- Do you take a calcium supplement? Yes ______ No ______
- Do you take a daily aspirin? Yes _____ No _____
- If born in 1945-1965, have you been screened for Hepatitis C? Yes ______ No ______
- Do you smoke? _______ If yes, how many years have you smoked? ______
  - If yes, are you interested in quitting? _______
  - If yes, when was your last lung cancer screening CT? _______
- Do you drink alcohol? Yes _____ No _____

- Do you have a living will or DPOA? Yes _____ No _____
- Do you pay your own bills and take care of your daily needs without assistance?
  - Yes ___ No___
- Do you have a history of falls in your home? Yes _____ No _____
- Do you feel unsteady when standing or walking? Yes ____ No ____
- Do you worry about falling? Yes ____ No _____
- Have you had a DEXA scan, or bone density test?
  - Yes ___ No ___
  - If yes, what year? _______
  - Do you have family history of osteoporosis? Yes ____ No ____
- For **women**:
  - When was your last mammogram?
    - Month, Year : _________
  - When was your last pelvic exam? _______
  - Do you have history of abnormal pap smear? ______
- For **men**, when was your last PSA, or prostate screening?
  - Month, Year : _______
- If you have family history of cancer, please list the type of cancer and the family member(s) affected, include children, siblings, parents, and grandparents :

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- Please list the names of your specialty providers (i.e. cardiologist, dermatologist)

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Your Medicare Annual Wellness Visit is a visit designated to speak to the provider about preventive health goals. If you are seen by a physician today and other acute illness symptoms or chronic disease management there may be additional charges billed for your service today.

Patient Signature _________________________ Date ___________________