ANDOVER
FAMILY
MEDICINE

Preventive Care Questionnaire - Medicare

Patient Name___________________________

Today's Date______________ **Age**________

- Have you had a pneumonia vaccine? (age 65+ or risk factors)
  - Yes _____ No ______
- Have you had a herpes zoster, or shingles, vaccine? (age 50+, 2 doses 8-week interval)
  - Yes _____ No______
- When was your last flu vaccine? (one time annually September through March)
  - Month/Year: __________
- Have you had the COVID-19 vaccine?
  - Yes _______ No ________ If yes, mo/yr of most recent booster? __________
- What year was your last tetanus vaccine? (1 dose every 10 years with Tdap once as an adult)
  - Year: ___________
- What year was your last colonoscopy? (every 10 years age 45-75 with no risk factors)
  - Year: ________
  - Doctor that performed the colonoscopy : _____________________
  - Results : Normal ___ Polyps ____ Other ____________________
  - If you have not had a colonoscopy, have you completed Cologuard or FIT stool testing?
    - If yes, what year? ________
  - Do you have a family history of colon cancer? ______
- Have you had a cardiac screening (EKG, stress test, or other testing)?
  - Year: ________
  - Do you have personal or family history of heart disease or stroke? Yes ____ No ____
  - Do you have family history of aortic aneurysm? (screen all M 65-75 h/o smoking) Yes ____ No ____
  - Do you take a statin medication for high cholesterol? Yes____ No_____ Intolerant ____
  - Do you take a daily 81mg aspirin? Yes ____ No _____
- Have you had a dilated eye exam?
  - Yes _____ (Name of eye doctor _________________) No _____
  - If yes, has it been less than 12 months ago? Yes ____ No ____
- Are you current on your dental exam? Yes ____ No ____
- Have you had fasting lab done in the last 3 years? Yes _____ No _____
  - Are you fasting today? Yes ____ No ____
- If born in 1945-1965, have you been screened for Hepatitis C? Yes _____ No _____
- Have you **ever** smoked, used chewing tobacco or electronic cigarettes: No____ Yes____ Type____________
  - If **Yes**, for how many years have you used tobacco products? _____
  - How many packs per day? _____
  - If you quit, at what age did you quit? ______
  - If you have a 20+ year history of smoking or tobacco use, have you had a CT lung cancer screening? (recommended annually age 50-80)
    - No ____ Yes _____

- Do you drink alcohol? Yes ____ No ____
- Do you take a multivitamin? Yes _____ No _____
- Do you take a vitamin D3 supplement? Yes _____ No _____
- Do you have a Living Will or Durable Power of Attorney? Yes _____ No _____
  - Have you provided a copy to our office for your chart? Yes______ No ________
  - Are you interested in a referral to help with DPOA/living will planning? Yes ____ No _____
- Do you pay your own bills and take care of your daily needs without assistance?
  - Yes ___ No____
- Do you exercise regularly? Yes ____ No ____
- Do you have a history of falls in your home? Yes _____ No _____
- Do you feel unsteady when standing or walking? Yes ____ No ____
  - If yes, do you have a cane, walker, or other assist device? Yes ____ No ____
- Do you worry about falling? Yes ____ No _____
- Do you have symptoms of urinary incontinence? Yes _____ No _____
- Have you had a DEXA scan, or bone density test? (recommended at age 65 for all women)
  - Yes ____ No ____
  - Do you have a family history of osteoporosis? Yes ____ No ____
- For **women**:
  - When was your last mammogram? (recommended annually for women 40-75)
    - Month, Year: _________
  - When was your last pelvic exam? (recommended every 3-5 years for cervical cancer screening in women ages 30-65) Year: _______
  - Do you have a personal history of an abnormal pap smear? ______
- For **men**, when was your last PSA, or prostate screening?
  - Month, Year: _______
  - Do you have a family history of prostate cancer? Yes _____ No ______
- 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, eye doctor, etc.)

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Your Medicare Annual Wellness Visit is a visit designated by Medicare to speak to the provider about preventive health goals. If you are seen by a physician today and have other acute illness symptoms or chronic disease management goals, there may be **additional charges** billed for your service today. A copy of your visit will be available on your patient health portal following today's visit.

Patient Signature:____ Date:_____________________