



ANDOVER
FAMILY
MEDICINE

Name: _____

DOB: _____ Age: _____

Today's Date: _____

Preventive Care Questionnaire - Medicare

- 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 ___

Please see next page

Name: _____

DOB: _____

Today's Date: _____

- 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:

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

PLEASE READ:

Your Medicare Annual Wellness Visit is intended to focus on preventive health and goal setting with your provider. Evaluation or management of new symptoms, acute issues, or chronic conditions **will be** billed separately. These services are not included in the Annual Wellness Visit and will be subject to deductible and/or co-insurance.

Patient Signature: _____

Date: _____

Please see next page

Patient Health Questionnaire (PHQ-9)

Name: _____

Date: _____

Over the last 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
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

For office coding: Total Score _____ = _____ + _____ + _____

Total Score _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all

Somewhat difficult

Very difficult

Extremely difficult