



Name: _____

DOB: _____ Age: _____

Today's Date: _____

Preventive Care Questionnaire - Medicare

- What year was your last colon cancer screening test?
 - Refer to Medical Record _____
 - 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?
Yes ____ No ____
 - Do you have a family history of colon cancer? Yes ____ No ____
- Have you had a cardiac screening (EKG, stress test, or other testing)? Yes ____ No ____
 - Do you have 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 aspirin? Yes ____ No ____
- Have you had a routine eye exam?
 - Yes ____ (Name of eye doctor _____) No ____
 - If yes, has it been less than 24 months ago? Yes ____ No ____
- Are you current on your dental exam? 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, have you had a CT lung cancer screening? (recommended annually age 50-80) Yes ____ No ____
- 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 ____
 - Name of DPOA(s) if applicable: _____
- Do you pay your own bills and take care of your daily needs without assistance?
 - Yes ____ No ____

Please see next page

Name: _____

DOB: _____

Today's Date: _____

- Do you exercise regularly? Yes ____ No ____
- Do you have a history of a fall in the last 12 months? 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 ____
- For **women**:
 - When was your last mammogram? (recommended annually for women 40-75)
 - Refer to Medical Record ____
 - Month, Year: _____
 - When was your last pelvic exam? (recommended every 3-5 years for cervical cancer screening in women ages 30-65)
 - Refer to Medical Record ____
 - Year: _____
 - Do you have a personal history of an abnormal pap smear? _____
- For **men**, when was your last PSA, or prostate screening?
 - Refer to Medical Record: ____
 - Month, Year: _____
- Do you have a family history of prostate cancer? Yes ____ No ____
- 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