



PREVENTION QUESTIONNAIRE

Patient Name: _____ DOB: _____

Today's Date: _____

For Men over 50 years old

	Yes	No	Not sure	<u>Date Done</u>
Have you had a colonoscopy in the last ten years?	Yes	No	Not sure	_____
Have you had a prostate exam in the last year?	Yes	No	Not sure	_____
Has your PSA been checked in the last year?	Yes	No	Not sure	_____
Has your Cholesterol been checked in the last year?	Yes	No	Not sure	_____
Have you had an influenza vaccine this year?	Yes	No	Not sure	_____
If 60+ years old, have you had a shingles vaccine?	Yes	No	Not Sure	_____
If 65+ years, have you had a <i>pneumovax</i> in the last 5 years?	Yes	No	Not sure	_____
If 65+ years have you ever had a bone density test (DXA)?	Yes	No	Not sure	_____
Have you had tetanus (DT) shot in the last 10 years?	Yes	No	Not sure	_____

For Men under 50 years old

Has your Cholesterol been checked in the last year?	Yes	No	Not sure	_____
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For Women

Have you had a pap smear within the last year?	Yes	No	Not sure	_____
If over 35, have you had a mammogram within the last year?	Yes	No	Not sure	_____
Have you had an influenza vaccine this year?	Yes	No	Not sure	_____
Has your Cholesterol been checked in the last year?	Yes	No	Not sure	_____
If 60+ years old, have you had a shingles vaccine?	Yes	No	Not Sure	_____
If 55+ years old, have you had a bone density test(DXA scan)?	Yes	No	Not sure	_____
If 50+ yrs, have you had a colonoscopy in the last ten years?	Yes	No	Not sure	_____
If 65+ yrs, have you had a pneumovax in the last 5 years?	Yes	No	Not sure	_____
Have you had a tetanus (DT) shot in the last 10 years?	Yes	No	Not sure	_____

For Diabetic Patients

Have you had an eye exam within the last year?	Yes	No	Not sure	_____
Have you ever seen a podiatrist for your feet?	Yes	No	Not sure	_____
Has your HgbA1c been checked within the last year?	Yes	No	Not sure	_____
Has your urine been checked for protein in the last year?	Yes	No	Not sure	_____

Please List Your Medications

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Please List Any Allergies to Medications

_____	_____
_____	_____
_____	_____
_____	_____