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PREVENTION QUESTIONNAIRE

Patient Name:____DOB: ____________

Today's Date: ________________________

For Men over 50 years old			**Date Done**
Have you had a colonoscopy in the last ten years?	Yes	No	__________
Have you had a prostate exam in the last year?	Yes	No	__________
Has your PSA been checked in the last year?	Yes	No	__________
Has your Cholesterol been checked in the last year?	Yes	No	__________
Have you had an influenza vaccine this year?	Yes	No	__________
If 60+ years old, have you had a shingles vaccine?	Yes	No	__________
If 65+ years, have you had a *pneumovax* in the last 5 years?	Yes	No	__________
If 65+years have you ever had a bone density test (DXA)?	Yes	No	__________
Have you had tetanus (DT) shot in the last 10 years?	Yes	No	__________

For Men under 50 years old			
Has your Cholesterol been checked in the last year?	Yes	No	__________

For Women			
Have you had a pap smear within the last year?	Yes	No	__________
If over 35, have you had a mammogram within the last year?	Yes	No.	__________
Have you had an influenza vaccine this year?	Yes	No	__________
Has your Cholesterol been checked in the last year?	Yes	No	__________
If 60+ years old, have you had a shingles vaccine?	Yes	No	__________
If 55+ years old, have you had a bone density test(DXA scan)?	Yes	No	__________
If 50+ yrs, have you had a colonoscopy in the last ten years?	Yes	No	__________
If 65+ yrs, have you had a pneumovax in the last 5 years?	Yes	No	__________
Have you had a tetanus (DT) shot in the last 10 years?	Yes	No	__________

For Diabetic Patients			
Have you had an eye exam within the last year?	Yes	No	__________
Have you ever seen a podiatrist for your feet?	Yes	No	__________
Has your Hgba1c been checked within the last year?	Yes	No	__________
Has your urine been checked for protein in the last year?			

Please List Your Medications

_____________________. _____________________. _____________________
_____________________ _____________________ _____________________
_____________________ _____________________ _____________________

Please List Allergies to Any Medications

_____________________. _____________________. _____________________
_____________________ _____________________ _____________________
_____________________ _____________________ _____________________

			Date Done
Yes	No	Not sure	__________
Yes	No	Not sure	__________
Yes	No	Not sure	__________
Yes	No	Not sure	__________
Yes	No	Not sure	__________

Yes	No	Not sure	__________
Yes	No	Not sure	__________
Yes	No	Not sure	__________
Yes	No	Not sure	__________
Yes	No	Not sure	__________
Yes	No	Not sure	__________

No Not sure __________

Yes

Please List Your Medications

Please List Any Allergies to Medications