FREDERICK
Integrated Healthcare
Network

MEDICARE SCREENING QUESTIONNAIRE - PREVENTATIVE MEDICINE

Patient Name: ________________________________ **Date of Birth:** ____________ **Today's Date:** _____________

To verify/complete our medical records and to enhance your overall medical care, please complete the following questions. Please give approximate date if exact date is unknown.
Note: Overdue/incomplete items may require a separate appointment for further clinical discussion.

Have you had 2 or more falls in the past year? *Yes* *No*

If yes, how many? ______________________

Did any of the fall(s) result in injury? *Yes* *No*

Over the past 2 weeks, have you felt down, depressed, or hopeless? *Yes** *No*

Over the past 2 weeks, have you felt little interest or pleasure in doing things? *Yes** *No*

*(*Do PHQ-9 and: drug treatment referral suicide risk assessment additional evaluation other intervention or follow-up)*

Last Flu Vaccine
Date: ______________________ Location: _________________________________ *N/A* *Never*

Last Pneumonia Vaccine
Date: ______________________ Location: _________________________________ *N/A* *Never*

Last Mammogram
Date: ______________________ Location/Specialist__________________________ *N/A* *Never*

Most Recent Colon Cancer Screening /
Colonoscopy:
Date: _______________________ Specialist Name: ___________________________ *N/A* *Never*

(If you have diabetes, please complete the following:

Last Hemoglobin A1c blood test Value:____________________________________ Date: ___________

Last Diabetic Eye (Retinal) Exam Specialist Name:____________________________ Date: ___________

____ _________________________

Patient/Guardian Signature Date

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Practice Staff Use Only: ❒ Information Abstracted By: _______________________ Date: __________
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