HEALTH SCREENING QUESTIONNAIRE - PREVENTATIVE MEDICINE

Patient Name: ______________________________ **Date of Birth:** _______________ **Today's Date:** _______________

Please complete the following questions. Please give approximate date/year if exact date is unknown.
Note: Overdue/incomplete items may require a separate appointment for further clinical discussion.

In the past year, have you had a fall with an injury? *Yes* *No*

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

Do you currently use any tobacco products (excludes vaping and marijuana)? *Yes* *No*

Flu vaccine (most recent)

Date: _______________ Location: ______________________________________ *Refuse / Allergy*

Mammogram (most recent)

Date: _______________ Location/Specialist: ____________________________________
Result (circle one): *Normal / Abnormal*

Colon Cancer Screening (most recent)

Date: ______________________ Location/Specialist: ____________________________________
Type: *Colonoscopy/Home Stool Cards/Fit-DNA/Cologuard/Flexible Sigmoidoscopy/CT Colonography*
Other: ____________________________________
Result (circle one): *Normal / Abnormal*

If you have diabetes, please complete the following

Last Hemoglobin A1c: Value: _________________________ Date: _______________

PHQ-2

Over the past 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				
2. Feeling down, depressed, or hopeless				

(If PHQ2 positive do, PHQ9 - drug treatment - referral - suicide risk assessment - additional evaluation - other intervention/follow-up)

____ ___________________

Patient/Guardian Signature Date

Practice Staff Use Only: ❒ Information Abstracted By: ___________________________
❒ Immunet Checked Date: _______/_______/_______

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