FREDERICK
Integrated Healthcare
Network

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.

Vaccines (most recent):

Flu vaccine Date: _____ Location: _____ *Refuse / Allergy*

Pneumonia Date: _____ Location: _____ *Refuse / Allergy*
Type (circle): *Prevnar 13 / Pneumovax*

Tetanus Date: _____ Location: _____ *Refuse / Allergy*
Type (circle): *DT / Tdap*

Shingles Date: _____ Location: _____ *Refuse / Allergy*
Type (circle): *Zostavax / Shingrix*

Please answer the following questions:

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*

Colonoscopy / Colon Cancer Screening (most recent)

Date: _____ Location: _____ Result: *Normal / Abnormal*
Type: *Colonoscopy/Home Stool Cards/Fit-DNA/Cologuard/Flexible Sigmoidoscopy/CT Colonography*
Other: _____

DEXA (bone density) scan (most recent)

Date: _____ Location/Specialist: _____

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)

For Women (most recent):

Mammogram Date: _____ Location: _____ Result: *Normal / Abnormal*

Pap Smear Date: _____ Location: _____ Result: *Normal / Abnormal*

Patients with Diabetes (most recent):

Hemoglobin A1c: Value: _____ Date: _____

Diabetic Eye Exam: Date: _____ Location/Specialist: _____
Result: *Retinopathy / No Retinopathy*

_____ _____
Patient/Guardian Signature Date

Practice Staff Use Only: ❒ Information Abstracted By: _____
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