

BRISTOL PARK

MEDICAL GROUP

PREVENTATIVE HEALTH QUESTIONNAIRE AGE 65 AND OLDER

NAME: _____ MEDICAL RECORD #: _____

DATE: _____ AGE: _____ MALE FEMALE

ALL PATIENTS

1. Have you had a Fecal Occult Blood Test (FOBT) in the last year?Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, what date? _____ results: _____ Where performed? _____
2. Have you had a Sigmoidoscopy in the last 5 years?Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, what date? _____ results: _____ Where performed? _____
3. Have you had a Tetanus/Diphtheria (dT) immunization in the last 10 years?Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, what year? _____ Where performed? _____
4. Have you had an Influenza vaccination in the last year?Yes <input type="checkbox"/> No <input type="checkbox"/>
5. Have you had a Pneumococcal vaccination?Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, what date? _____ Where performed? _____
6. Do you have an Advance Directive?Yes <input type="checkbox"/> No <input type="checkbox"/> If not, are you interested in information on Advance Directives?Yes <input type="checkbox"/> No <input type="checkbox"/>
7. Have you been counseled regarding osteoporosis?Yes <input type="checkbox"/> No <input type="checkbox"/>
8. Are you a non-smoker ?Yes <input type="checkbox"/> No <input type="checkbox"/>

WOMEN 65 TO 69

1. Have you had a mammogram within the past 1 to 2 years?Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, what date? _____ results: _____ Where performed? _____

MEN ONLY

1. Men over age 50 Have you been counseled regarding the risks and benefits of prostate cancer screening? Yes <input type="checkbox"/> No <input type="checkbox"/>
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PATIENT/GUARDIAN SIGNATURE

COMMENTS/ACTION TAKEN:

PROVIDER SIGNATURE