FREDERICK
Integrated Healthcare
Network

MEDICARE 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 d), 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: _____
☐ Immunet Checked Date: ____/____/____

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814 Toll House Avenue
Frederick, MD 21701
(301) 662-8310

Patient Name_____ **DOB**_____

Internal Medicine Health History Questionnaire

Main reason for today's visit and/or concerns:

_____

_____

Patient Pharmacy: _____

Patient Lab: _____

Patient Imaging: _____

Allergies (to medications, food, pollen, etc. and how it affects you):

Allergen	Reaction

Medications (list all prescription and over the counter drugs):

Drug Name	Strength	Frequency Taken

Immunizations:

Chickenpox	Date: _____	Meningococcus	Date: _____
Influenza	Date: _____	MMR	Date: _____
Gardasil/HPV	Date: _____	Pneumonia	Date: _____
Hepatitis A	Date: _____	TDAP	Date: _____
Hepatitis B	Date: _____	Tetanus	Date: _____
Meningococcus	Date: _____		

Patient Name_____ **DOB**_____

Family History (circle):

M. Grandmother	**M. Grandfather**	**P. Grandmother**	**P. Grandfather**
Alcoholism	Alcoholism	Alcoholism	Alcoholism
Arthritis	Arthritis	Arthritis	Arthritis
Depression	Depression	Depression	Depression
Cancer	Cancer	Cancer	Cancer
Diabetes	Diabetes	Diabetes	Diabetes
Heart Disease	Heart Disease	Heart Disease	Heart Disease
Hypertension	Hypertension	Hypertension	Hypertension
Osteoporosis	Osteoporosis	Osteoporosis	Osteoporosis
Stroke	Stroke	Stroke	Stroke
Other	Other	Other	Other
Father	**Mother**	**Brother(s)**	**Sister(s)**
Alcoholism	Alcoholism	Alcoholism	Alcoholism
Arthritis	Arthritis	Arthritis	Arthritis
Depression	Depression	Depression	Depression
Cancer	Cancer	Cancer	Cancer
Diabetes	Diabetes	Diabetes	Diabetes
Heart Disease	Heart Disease	Heart Disease	Heart Disease
Hypertension	Hypertension	Hypertension	Hypertension
Osteoporosis	Osteoporosis	Osteoporosis	Osteoporosis
Stroke	Stroke	Stroke	Stroke
Other	Other	Other	Other

Social History:

Do you smoke? Yes/No

If so, how much? _____

For how long? _____

Education level: _____

Occupation: _____

Are you employed? Yes/No

Do you live: Alone/With others

Number of children: _____

Exercise level: None/Occasional/Moderate/Heavy

Stress level: Low/Medium/High

Any diet restrictions? _____

Caffeine use: None/Occasional/Moderate/Heavy

Alcohol use: None/Occasional/Moderate/Heavy

Chewing tobacco: None/1 time per day/2-4 times per day/5+ times per day

Illicit drug use: _____

Patient Name_____ **DOB**_____

GYN History (women only):

Last PAP smear	Date: _____	Result (circle):	Normal/Abnormal
Last mammogram	Date: _____	Result (circle):	Normal/Abnormal

Last menstrual cycle Date: _____ Age of menopause: _____

OB History (women only):

Births: _____ Miscarriages Induced: _____
Cesarean sections: _____ Miscarriages Spontaneous: _____

Sexual History:
Are you sexually active (circle)? Yes/No
My current sexual partner is (circle): Male/Female
Do you use condoms (circle)? Yes/No
Birth control used? _____

Past Surgical History:

Surgery	Reason	Date/Year	Location

Patient Name_____ **DOB**_____

Past Medical History (check):

ADD/ADHD	AIDS/HIV	Abuse/Domestic Violence
Allergies/Hay fever	Anemia	Anesthesia Complications
Anxiety Disorder	Arthritis	Asthma
Autism Spectrum Disorder	Bedwetting	Birth Defect/Inherited Disease
Bladder/Kidney Problem	Blood Diseases	Blood Transfusion
Breast Cancer	Breast Problems	COPD
Cancer	Chickenpox	Chronic Ear Infections
Congestive Health Failure	Constipation	Coronary Artery Disease
Depression	Developmental Disorder	Diabetes
Difficulty Swallowing	Diverticulitis	Ear or Hearing Problems
Eating Disorder	Eczema	Endometriosis
Fibromyalgia	GI Problems	Gout
Headaches	Heart Disease	Heart Problems
Hepatitis	High Cholesterol	High Hospitalizations
Hypertension	Hyperthyroidism	Hypothyroidism
Infertility Disorder	Kidney Disease	Kidney Stone
Liver Disease	Lung Disease	MRSA Exposure
Meniere's Disease	Mental Disorder	Mental Illness
Muscle/Joint/Bone Problems	Obesity	Osteoporosis
Other	Ovarian Cancer	Polyps
Pre-Eclampsia	Pulmonary Embolism	Reflux/GERD
Seizure Disorder/Epilepsy	Skin Problems	Stroke
Thrombophlebitis	Thyroid Problems	Tuberculosis
Varicosities	Vision/Eye Problems	

Any other information you would like to tell us about your health?

_____

_____

_____