Interval Review of Systems/HEDIS Questionnaire/Preventive Visit ***DATE OF VISIT***

Please answer ALL questions completely if not present on your PHR or put N/A in area that does not pertain to you----if you need assistance please ask our staff for help.

First day of last menstrual period _____

(If post menopausal give year of last Period)

Number of times you have been pregnant?: ____

Number of completed pregnancies: _____

Date of last pregnancy: _____

If you are under age 55, what method of birth control do you use (circle your response)?

Abstinence Vasectomy TUBAL Condom/foam

Diaphragm IUD Nuva Ring Depo-Provera

IF BIRTH CONTROL PILLS-what kind?_____

How many years have you used the pills? _____

Are you planning a pregnancy in the next 6-12 months? YES NO

Do you take any of the following pills?

Folic Acid (400 mg)	YES	NO
Calcium (1200 Mg-a day)	YES	NO
Vitamin D (800 Units a day)	YES	NO
Estrogen (Premarin/estrace/Bioidentical)	YES	NO
Progesterone (Provera/bioidentical)	YES	NO

Have you had Abnormal Pap smears? YES NO

If yes, date: _____ problem: _____

For pap abnormality, did you have any of the following done?:

Colposcopy	YES	NO
Biopsies	YES	NO
Surgery (CONE, LEEP, CRYO)	YES	NO

Abdominal or pelvic surgery or special tests Other than above ? YES NO

If yes, what: _____ when: _____

Do you have any of the following: (If yes, please makes sure we discuss it with you.? ANSWER YES or NO, or ENTER N/A in block

1. Problems with present method of birth control? _____
2. Bleeding between periods or since periods stopped?_____
3. Pain with intercourse or periods?_____
4. Any problem with interest in or enjoying intercourse?_____
5. A new or enlarging lump in breast? If yes what side?_____
6. Need instruction on Self Breast Exam? _____
7. Change in size/firmness of stools, or presence of blood or mucus?_____
8. Change in size/color of a skin mole?_____
9. Severe headaches, migraines?_____
10. Pain in the leg, chest, abdomen or joints?_____
11. History of blood clot in legs or lungs?_____
12. High Blood Pressure or heart attack or palpitations?_____
13. Trouble falling or staying asleep? _____ _____
14. Often feeling down, depressed or hopeless during the past month? ____
15. Often having little interest or pleasure in doing things during the past month? _____
16. Conflict in your family or relationships, sometimes handled by pushing, hitting or cruelty? _____

Patient Notes (make notes here or use back of form):

Have you ever had a mammogram? YES NO

Date of LAST mammogram_____ Where?

Any abnormal mammograms IN PAST? YES NO

If yes, date: _____ problem: _____

For abnormality, did you have any of the following?

Biopsy (needle or open)	YES	NO
Cyst fluid drained	YES	NO

Surgery (lumpectomy/Mastectomy) YES NO

Which breast? LEFT RIGHT

Have you ever had Head/Neck or Abdominal Radiation Treatments'? YES NO

Osteoporosis (thin-bone) screening:

Is there a history of any relatives with the following: stooping over or losing height as they got older, "thin bones," hip fractures, If yes, relation: _____

Have you had any of the following:

Height loss	YES	NO
Broken hip or wrist	YES	NO
Bone-density test (DEXA)	YES	NO

Do you or have you taken any of the following:

Steroids (prednisone)or medications for thyroid, seizures or thin bones? YES NO

Have you ever used tobacco? YES NO

If yes- CHEW SMOKE CIG SMOKE Cigar

If not currently smoking, what year did you quit?

I smoked an average of _____number of packs/day.

I smoked for _____years.

If still smoking-when are you planning to quit?

now next 6 months sometime never

Do you drink alcohol? YES NO

(if yes answer the following questions) # of drinks _____

DAILY WEEKLY MONTHLY HOLIDAYS

Please answer YES or NO to the following questions:

1. Have you ever felt you should cut down on your drinking?
2. Have people ever annoyed you by nagging you about your drinking?
3. Have you ever felt guilty about your drinking?
4. Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover?

Additional Prevention/Health/Safety questions

Diet (circle): Regular diet Low Fat Weight Loss

Special:_____

Exercise you participate in: Typr of Activity_____

Days per week _____Time/duration _____ minutes

Exertion Level: stroll mild heavy

Do you always wear seat belts?	YES	NO
Are your Immunizations up to date? (see posted list)	YES	NO
Does your house have a working smoke detector?	YES	NO
Have you had any falls in the last YEAR?	YES	NO

Your last DENTAL exam? _____

Your last EYE exam? _____

Provider Notes/review signature: