Interval Review of Systems/HEDIS Questionnaire/Preventive Visit

Please answer ALL questions completely to update or verify information in your records currently. Please circle your answer or put N/A in area that does not pertain to you----if you need assistance please ask our staff for help.

What method of birth control do you use (circle your response)?

Abstinence Vasectomy TUBAL Condom/foam

Do you take any of the following Supplements or meds?

Multiple Vitamin	YES	NO
Calcium (1200 Mg-a day)	YES	NO
Vitamin D (800 Units a day)	YES	NO
Testosterone	YES	NO
Muscle Supplement	YES	NO
Saw Palmetto	YES	NO

Have you had Abnormal Prostate findings? YES NO

If yes, date: _______ problem: ______________

If yes, did you have any of the following done?:

Biopsies	YES	NO
Surgery (TURP/TUNA)	YES	NO

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

If yes, what: ________________ when: ____________________

Have you ever had a mammogram or breast enlargment? YES NO

If yes ever had a mammogram ? Where?_________________________

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

1. Difficulty with urine stream strength or flow rate on urination __________
2. Sexual problems (getting and keeping erections, completing intercourse, etc.? ___________________________________
3. Pain with intercourse or blood in sperm?_________________
4. Any problem with interest in or enjoying intercourse?________
5. A new or enlarging lump in testicle? If yes what side?______
6. I need instruction on Self Testicular self-exam? ___________
7. Change in size/firmness of stools, or presence of blood or
8. mucus in stool?_____
9. Difficulty with heartburn, reflux or difficulty swallowing?
10. Change in size/color of a skin mole?_________________
11. Severe headaches, migraines, or numbness?_________________
12. Pain in the leg, or joints?______________
13. Chest pain, Shortness of breath or palpitations?
14. History of blood clot in legs or lungs?__________________
15. High Blood Pressure or heart attack in past? ______________
16. Trouble falling or staying asleep? _________ __________
17. Conflict in your family or relationships, sometimes handled by pushing, hitting or cruelty? __________________________

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

Screening (Male and Female)

Have you felt down, depressed or hopeless during the past month? Yes___ No____

I have little interest or pleasure in doing things during the past month? Yes___ No___

Have you ever had Head/Neck or Abdominal Radiation Treatments as a child or adult?
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 PIPE

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?
5.

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:

NAME: DOB: ***DATE OF VISIT:***