Patient Preventative Care Questionnaire

(For patients 50 years or Older)

2020 1st QTR

3131 Princeton Pike Bld.4A Suite 100
Lawrenceville, NJ 08648

Dear Patient,

At PSFM your overall health is important to us. To help ensure we are doing all that we can do to keep you healthy as possible, we ask that all patients 50 years or older fill out this "Patient Preventative Care Questionnaire". Thank You!

Date: _____

Name: _____

D.O.B. _____ Gender: ☐ M ☐ F ☐ T

Doctor you are seeing today:

- ☐ **Peter Wenger, MD**
- ☐ **Richard Levandowski, MD**
- ☐ **Richard Kim, MD**
- ☐ **Cara Barlis, MD**
- ☐ **Jennifer Lhost, MD**
- ☐ **Lauren Eisenhauer, APN**
- ☐ **Kaceyanne Cerankowski, PA-C**

Alcohol Screening

Did you have a drink containing alcohol in the past year? ☐ **Yes** ☐ **No**

If "Yes", how often did you have a drink containing alcohol in the past year?

☐ Monthly or less ☐ 2 - 4 times a month ☐ 2 - 3 times a week ☐ 4 or more times a week

If "Yes", how many drinks did you have on a typical day when you were drinking in the past year?

☐ 1 - 2 drinks ☐ 3 - 4 drinks ☐ 5 - 6 drinks ☐ 7 - 9 drinks ☐ 10 or more drinks

If "Yes", how often did you have 6 or more drinks on one occasion in the past year?

☐ Never ☐ Less than monthly ☐ Month ☐ Weekly ☐ Daily or almost daily

Tobacco Control

Are you a:

☐ current smoker

☐ former smoker How Long _____? When did you stop _____?

☐ non-smoker

☐ current every day smoker

☐ current some day smoker

☐ tobacco use other than cigarettes Please list _____

Patient Health Questionnaire (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems?
(Use "x" to indicate you answer)

	Not at all	Several days	More than half the days	Nearly every day
	0	1	2	3
1) Little interest or pleasure in doing things	☐	☐	☐	☐
2) Feeling down, depressed, or hopeless	☐	☐	☐	☐
3) Trouble falling or staying asleep, or sleeping too much	☐	☐	☐	☐
4) Feeling tired or having little energy	☐	☐	☐	☐
5) Poor appetite or overeating	☐	☐	☐	☐
6) Feeling bad about yourself or that you are a failure, or have Let yourself or family down	☐	☐	☐	☐
7) Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
8) Moving or speaking so slowly that other people could have noticed; or the opposite, being so fidgety or restless that you have been moving around a lot more than usual	☐	☐	☐	☐
9) Thoughts that you would be better off dead or hurting yourself in some way	☐	☐	☐	☐

Influenza Vaccination

Did you have a Flu vaccine this year? ☐ No ☐ Yes If yes, when _____

Pneumococcal Vaccination

Did you ever have a Pneumococcal vaccine? ☐ No ☐ Yes If yes, when _____

Colorectal Cancer

Have you had a colonoscopy? ☐ No ☐ Yes If yes, when _____

Results? □ Normal □ Abnormal If abnormal, results _____

Breast Cancer (Female Patients Only)

Have you had a mammogram? ☐ No ☐ Yes If yes, when_____?

Results? □ Normal □ Abnormal If abnormal, results _____

Falls Assessment

Did you have 2 or more falls in the last year? ☐ No ☐ Yes

Did you have any falls that caused injury in the last year? ☐ No ☐ Yes

Other

Do you currently take baby aspirin? ☐ No ☐ Yes

If diabetic, have you had a vision test in the last year? ☐ No ☐ Yes If yes, when_____

Results? □ Normal □ Abnormal If abnormal, results _____