TRIANGLE FAMILY MEDICINE

PREVENTATIVE CARE QUESTIONNAIRE (18-64y/o)

Patient Name: _____ Date of Birth: _____

If applicable, please write the date of service, performing office information, and results of your last preventative screening.

Colon Cancer Screening (Colonoscopy/Cologuard/SHIELD) *Individuals aged 45-75 y/o – every 10 years if normal.*

Date of Service	Results	Office Information

Do you have a personal or family history of colorectal cancer? _____

Bone Density Scan (DEXA) *Women aged 65+, Men aged 70+, Women age 50-64 w/ risk factor, Men age 50-69 w/ risk factor.*

Date of Service	Results	Office Information

Do you have a family history of osteopenia/osteoporosis? _____

Cervical Cancer Screening (PAP Smear) *Women age 21-65 – every 3 years*

Date of Service	Results	Office Information

Breast Cancer Screening (Mammogram) *Women age 40-74 – every 2 years*

Date of Service	Results	Office Information

Do you have a family history of breast cancer? _____

Prostate Cancer Screening *Men aged 50+*

Date of Service	Results	Office Information

Do you have a family history of prostate cancer? _____

Dental Cleaning *Every 6 months*

Date of Service	Office Information

Skin Check *Beginning in early 20s, every 3 years until age 40. Then 1x a year.*

Date of Service	Results	Office Information

Do you have a family history of skin cancer? _____

Comprehensive Eye Exam *Individuals age 18-64, every 2 years.*

Date of Service	Results	Office Information

Adult Hearing Screening

Date of Service	Results	Office Information

Have you had a flu shot this year? NO YES If yes, when? _____

Have you had a shingles shot? NO YES If yes, when? _____