Sample patient self-assessment form: Medicare Preventive Questionnaire

Since your last visit here:

- Have you been diagnosed with any new medical conditions? ___Yes___No

If Yes, details:_____

- Have you undergone any recent surgical procedures? ___Yes___No

If Yes, details:_____

- Have you had any medication, vitamin, or supplement changes? ___Yes___No

If Yes, details:_____

- Have any close family members developed any serious illnesses? ___Yes___No

If Yes, details:_____

- Have you changed your use / nonuse of tobacco or alcohol? ___Yes___No

If Yes, details:_____

Please describe your current diet (check all that apply):

___ Well Balanced, Controlled Portions ___Unbalanced ___Excessive Portions

___ Low Salt ___Low Fat ___Low Carbs ___Restricted Calories (_____ cal/ day)

___ Other: _____

Please describe your current activity level:

___ Minimal ___ Active, but No Exercise ___Some Exercise ___Regular Exercise

Have you had an eye examination within the last year? ____Yes ____ No

Name of eye doctor_____

Do you have any difficulties with your hearing? *(Are you unable to hear your fingers rubbing together when you hold your arms outstretched?)*

_____Yes _____Hearing aid _____ No difficulty

Please list any other doctors regularly involved with your care:

Name _____ Specialty _____

Phone/Fax if available_____

Name _____ Specialty _____

Phone/Fax if available_____