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**Patient Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date \_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Provider Initials\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Annual Screening Questionnaire**

As part of your medical history, we are respectfully requesting our patients complete a brief questionnaire for preventive screenings. This is a partial list of CDC recommended screenings which serve the purpose to keep you healthy.

1. **Flu shot**

Have you received your flu shot for the current season or upcoming season?

**Yes**  🞏 **No** 🞏

If not, do you intend to? **Yes** 🞏 **No** 🞏

1. **Pneumococcal shot**

Have you ever received a pneumococcal shot? **Yes** 🞏 **No** 🞏

If not, do you intend to this year? **Yes**  🞏 **No** 🞏

1. **Colorectal cancer screening**

Have you obtained colorectal cancer screening following the guidelines recommended by your primary care physician? **Yes** 🞏 **No** 🞏

1. **Breast cancer screening (mammograms)**

If applicable, have you obtained breast cancer screening following the guidelines recommended by your primary care physician? **Yes**  🞏 **No** 🞏 **N/A** 🞏

1. **Osteoporosis screening DEXA Scan (Bone mass measurements)**

If applicable, have you obtained a DEXA scan for osteoporosis screening following the guidelines recommended by your primary care physician? **Yes**  🞏 **No** 🞏 **N/A** 🞏

1. **Smoking and tobacco use**

Do you currently use tobacco? **Yes** 🞏 **No**  🞏

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Patient Signature Date