Intake Forms for Preventive Services for Men and for Women (non-pregnant)

Consistent with UMHS Guideline on Adult Clinical Preventive Care

Michael D. Fetters, MD and R. Van Harrison, PhD, 12/7/11

Keeping track of all preventive services relevant to an individual patient can be complex. More than 100 risk factors relate to one or several of more than 30 preventive services. The following intake forms for men and non-pregnant women incorporate the USPSTF strongly recommended (level A) and recommended (level B) adult preventive services and the ACIP recommended adult vaccinations. They are based on Table 1 in the UMHS clinical guideline for Adult Clinical Preventive Care, listing only risk factors that prompt relevant preventive services.

While clinicians are welcome to use the forms, no recommendation is made regarding using them. Their usefulness is currently being studied. The content and format will continue to evolve with experience. They represent an advance in the systematic provision of preventive care over depending on clinician recall, forms developed for other purposes, and forms that address only a few of the most common preventive services.

Although these forms are an advance in systematically considering preventive services for specific individuals, they have several limitations:

Operational recommendations. Many risk factors have been stated in general terms because of limitations on available evidence. For example, USPSTF does not provide a time frame for defining “new” sexual partners when assessing risk for sexually transmitted infections. Similarly ACIP recommends influenza vaccination for persons with “chronic illnesses,” providing examples of only common chronic illnesses. In developing the intake forms expert opinion guided some necessarily arbitrary decisions concerning the content. For example, risk factors regarding sexual activity, tobacco and alcohol were framed within past year.

Information not addressed in recommendations. USPSTF and ACIP recommendations do not address several aspects of preventive care that many physicians support based on experience or philosophical beliefs (e.g., women taking calcium and vitamin D supplements, screening for domestic violence). The forms only address the recommended preventive services. In a few instances, items were added to facilitate the logical flow of information. For example, a question about method of birth control was added to the form for women to precede the item about sometimes having sex with men without a condom/barrier.

Inefficiencies with paper–and–pencil format. In principle, once a risk factor is noted that requires a service, other risk factors for the same service need not be considered. The paper–and–pencil format requires that patients provide all of the information for subsequent clinician review.

Not linked to other intake forms or existing information. Information requested in these forms may duplicate some information collected in general intake forms or already available in the medical record. A long term goal is the development of integrated electronic intake forms and medical records that optimize the collection and utilization of clinical information. One part of this broader goal is the systematic specification of information needed to determine preventive services for an individual patient.

Use with local clinic’s review of systems form. The form for preventive care services does not replace the usual review of systems for management of medical problems, which may be needed for E/M coding. Using the preventive care services form in conjunction with the medical practice’s current form for review of systems is likely to collect efficiently most needed initial information from adult patients.
PREVENTIVE CARE QUESTIONNAIRE FOR:

Name: ____________________________

CPI#: ____________________________

University of Michigan Health System

Please answer the following to help your health care provider assess preventive services appropriate for you. For “yes,” check the box and, if indicated, fill in information.

What are your current concerns or questions? ____________________________________________

________________________________________________________________________________

__________________________________________________________________________

Medical History

☐ High blood pressure
☐ High/abnormal cholesterol
☐ Heart attack or other heart problems
☐ Aneurysm of aorta (abdomen)
☐ Atherosclerosis (cholesterol in blood vessels)
☐ Coronary artery disease
☐ Overweight or obesity
☐ Diabetes mellitus (“sugar diabetes”)
☐ Chronic Lung disease (e.g., asthma, COPD, emphysema)
☐ Neurological disease
☐ Kidney disease, chronic (not urinary tract infections)
☐ Hemodialysis
☐ Rheumatoid arthritis or other immunity-related disease
☐ Regular oral steroid use (e.g., prednisone, medrol)
☐ Sickle cell disease (not trait only), thalassemia, or other gene-related blood diseases
☐ Spleen disease
☐ Chronic liver disease (e.g., chronic-hepatitis, cirrhosis, jaundice)
☐ Sexually transmitted infection
☐ AIDS or HIV infection
☐ Low Immunity. If “yes,” check if:
  ☐ HIV (CD4<200 cells/µL) ☐ leukemia or lymphoma,
  ☐ recent bone marrow transplant ☐ solid organ transplant
  ☐ birth-related immune deficiency ☐ other
  ☐ cancer now or treatment with chemotherapy
  ☐ radiation or long-term steroids (> 20 mg prednisone)
☐ Blood transfusion from 1978 to 1985
☐ Blood transfusions repeatedly
☐ Leaking of cerebrospinal fluid (liquid around the brain)
☐ After age 39, had any bone fracture due to little or no injury
☐ Other(s)_________________________________________________________________

For clinician’s consideration

Lipid, DM screens, Counsel diet
Lipid, DM screens, Counsel diet
Lipid, DM screens, Counsel diet
Lipid, DM screens, Counsel diet
Lipid, DM screens, Counsel diet
DM screens, Counsel diet; FLU, PVX
Counsel diet; if BMI > 30 intensive intervention
Lipid, glaucoma screens *; FLU, PVX
PVX
PVX
PVX
PVX, HBV
PVX
PVX
PVX, Menactra
PVX, Menactra
PVX, HAV, HBV
HIV, Intensive STI counsel
PVX, HAV, HBV

NO live vaccines (Flumist, Herpes Zoster, Measles-Mumps-Rubella, Varicella)

HIV
HAV, HBV
PVX
Assess OP risk; DEXA scan ≥60y if high risk (BMI <20)
**Surgery**
- □ Cochlear implant (s) for hearing
- □ Bone marrow or other organ transplant
- □ Splenectomy (surgical removal of the spleen)
- □ Other(s)___________________________________________

| PVX | Menactra, FLU-6 months after transplant, **NO** live vaccines, Menactra |

**Social History**
- □ Freshman student living in a dorm
- □ College student
- □ Health care worker/student (nurse, doctor, dentist, etc)
- □ Will be with adoptee from country with hepatitis A, first 60 days here
- □ Work around individuals with low immune condition
- □ Other possible work exposure blood/body fluids (safety worker, etc)
- □ Work in laboratory with hepatitis A or neisseria meningitis

| 2nd MMR, Menactra |
| 2nd MMR |
| 2nd MMR, HBV |
| HAV |
| VZV |
| HBV |
| HAV or Menactra |

**Sexual Health**
- □ Not started sexual activity
- □ Sexually active with female partner(s). If yes:
  - □ Using birth control? If yes, method/type_______________
- □ Sexually active with male partner(s)
- □ Sometimes have sex without condoms/barrier
- □ Sexual partner ever had sexually transmitted infection
- □ Started sex with new partner in the last year
- □ Had sex with more than one partner in the last year
- □ Current sex partner had other sex partner(s) in the last year
- □ Self or partner(s) was ever sex worker or in sexual exchange activity
- □ Desire Hepatitis B vaccine
- □ Desire testing for HIV

| [Counsel on methods] |
| GC, HAV, HBV, HIV, Syph |
| HIV, +/- Syph, Intensive STI counsel |
| HIV, +/- Syph, Intensive STI counsel |
| HIV, +/- Syph, Intensive STI counsel |
| HBV, HIV, +/- Syph, Intensive STI counsel |
| HBV, HIV, +/- Syph, Intensive STI counsel |
| HBV, Syph, Intensive STI counsel |
| HIV, Syph, Intensive STI counsel |

**Mood**
- □ Over the past 2 weeks have you felt down, depressed or hopeless? 
- □ Over the past 2 weeks have you felt little interest or pleasure in doing things?

| Counsel |

**Domestic concerns**
- □ Are you afraid of anyone close to you? 
- □ Have you ever been hit, slapped, kicked, pushed or shoved or otherwise physically hurt by your partner or someone close to you? 
- □ Are you frequently upset, ashamed or embarrassed by someone close to you? 
- □ Has anyone forced you to have sexual activities?

| Consider who/when. Counsel/refer. * |

**Exercise, Diet, and Alcohol**
- ___Number days you exercise per week
- ___Number of minutes you exercise on days that you exercise
- ___Number of servings (1/2 cup each) of fruit & vegetables you eat daily

| Counsel ≥5 times |
| Counsel ≥30 mins |
| Counsel 5 servings |
Drank alcohol in the past year. If “yes”:
Types used: □ beer □ wine □ liquor □ other
___Number of drinks per day
___Number of drinks per week
___Most drinks per day during the past year
☐ Have you ever felt you should cut down on drinking
☐ Have people annoyed you by criticizing your drinking
☐ Have you ever felt bad or guilty about your drinking
☐ Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover?

Tobacco and Substance Use
☐ Used tobacco in the past year. If “yes”:
Types used: □ cigarettes □ cigars □ pipe □ smokeless □ chew
☐ Want to quit smoking/using tobacco?
☐ Injected recreational drug use (e.g., heroin) ever. Please list drugs injected: ________________________________

Age-Related Preventive Screening
☐ Age is 18 or older?
☐ Age is 35 or older?
☐ Age is from 50 to 75?
☐ Checked/screened for colon cancer. If “yes,” for most recent:
   Date: __________
   Type: □ stool blood test □ flexible sigmoidoscopy □ colonoscopy □ barium enema
☐ Any polyps found
☐ Age is 60 or older?
☐ Age is 65 or older?
☐ Are you concerned that you have hearing loss?
☐ Age is from 65 to 75 and ever smoked

Immunizations and Preventable Infections
☐ Tetanus vaccine—Date most recent?___________
☐ Health care worker
☐ Care provider to child <1 year old
☐ Influenza vaccine—Date most recent?___________
☐ Pneumovax vaccine—Date most recent?___________
☐ Herpes Zoster vaccine—Date?___________
☐ Hepatitis B vaccine (series of 3)—Dates?______ _______ _______
☐ Hepatitis A vaccine (series of 3)—Dates?______ _______ _______
☐ Chicken pox infection or ☐ chicken pox vaccine—Date?___________
☐ Measles infection or ☐ measles vaccine—Date?___________

Max men: 2/d, 14/wk

Counsel; current smoker: PVX

Counsel

HIV, HAV, HBV

HTN

Lipid

CRC q 1-10y by screen type, consider PSA & DRE

Counsel

Counsel

Counsel

HZV

PNV, FLU high dose?

Hearing test

AAA

Td/Tdap q10y (Tdap 1x)

Tdap if >2y since Td

Td If >2y since Td

FLU

PNV

HZV

HBV

HAV

VZV if no

MMR if no
**Family History:** Please circle any condition appearing below that has affected any blood relative.

- □ Colon cancer? If yes: who & age at onset __________________
- □ Breast cancer? If yes: who & age at onset __________________
- □ Ovarian cancer? If yes: who & age at onset __________________
- □ Prostate cancer? If yes: who & age at onset __________________
- □ Heart attack? If yes: who & age at onset __________________
- □ Diabetes Mellitus? If yes: who & age at onset __________________
- □ Abdominal aortic aneurysm in family member
- □ Glaucoma in family member
- □ Family member to get organ transplant in next 6 months
- □ Family member is person with hepatitis B infection
- □ Family member, other medical condition? ____________

**Special Considerations**

- □ Living in nursing home or long-term care facility
- □ Ever in correctional facility
- □ African American ancestry and age 50 or older
- □ Hispanic American ancestry and age 50 or older
- □ Exposed to mumps or measles outbreak?

**Review of Systems • Which of the following affect you? Circle responses.**

<table>
<thead>
<tr>
<th>General:</th>
<th>fever</th>
<th>decreased/no energy</th>
<th>loss appetite</th>
<th>unintended weight</th>
<th>gain/loss</th>
</tr>
</thead>
<tbody>
<tr>
<td>Head:</td>
<td>headache</td>
<td>injury</td>
<td>none</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eye:</td>
<td>visual change</td>
<td>crossed discharge</td>
<td>redness</td>
<td>puffiness</td>
<td>none</td>
</tr>
<tr>
<td>Ear:</td>
<td>difficulty with hearing</td>
<td>pain</td>
<td>discharge</td>
<td>none</td>
<td></td>
</tr>
<tr>
<td>Nose:</td>
<td>runny nose</td>
<td>nasal congestion</td>
<td>nose bleed</td>
<td>none</td>
<td></td>
</tr>
<tr>
<td>Mouth/throat:</td>
<td>sore throat</td>
<td>difficulty swallowing</td>
<td>dental problems</td>
<td>none</td>
<td></td>
</tr>
<tr>
<td>Lung:</td>
<td>shortness of breath</td>
<td>coughing</td>
<td>chest pain</td>
<td>wheezing</td>
<td>sputum</td>
</tr>
<tr>
<td>Heart:</td>
<td>pale</td>
<td>cyanosis</td>
<td>chest pain</td>
<td>leg swelling</td>
<td>faint</td>
</tr>
<tr>
<td>Gastrointestinal:</td>
<td>abdominal pain</td>
<td>nausea</td>
<td>vomiting</td>
<td>diarrhea</td>
<td>constipation</td>
</tr>
<tr>
<td></td>
<td>distention</td>
<td>blood in stool</td>
<td>black/tarry stool</td>
<td>none</td>
<td></td>
</tr>
<tr>
<td>Genitourinary:</td>
<td>painful urination</td>
<td>urine retention</td>
<td>incontinence</td>
<td>difficulty urinating</td>
<td>none</td>
</tr>
<tr>
<td></td>
<td>blood in urine</td>
<td>none</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Musculoskeletal:</td>
<td>deformities</td>
<td>joint pain</td>
<td>joint swelling</td>
<td>difficulty in moving</td>
<td>none</td>
</tr>
<tr>
<td>Neurologic:</td>
<td>dizziness</td>
<td>weakness</td>
<td>hand shakiness</td>
<td>seizures</td>
<td>none</td>
</tr>
<tr>
<td>Skin:</td>
<td>rash</td>
<td>itching</td>
<td>color change</td>
<td>easy bruising/bleeding</td>
<td>change in mole</td>
</tr>
<tr>
<td>Psychiatric:</td>
<td>frequent mood change</td>
<td>nervousness</td>
<td>tension</td>
<td>feeling down</td>
<td>unable to sleep at night</td>
</tr>
</tbody>
</table>

* Not in USPSTF
**PREVENTIVE CARE QUESTIONNAIRE FOR:**  
**WOMEN (not pregnant)**  
University of Michigan Health System

Please answer the following to help your health care provider assess preventive services appropriate for you. For “yes,” check the box and, if indicated, fill in information.

Name:  
CPI#:  
DOB:  
Date:

What are your current concerns or questions? ____________________________________________

**Medical History**

- [ ] Pregnant
- [ ] High blood pressure
- [ ] High/abnormal cholesterol
- [ ] Heart attack or other heart problems
- [ ] Aneurysm of aorta (abdomen)
- [ ] Atherosclerosis (cholesterol in blood vessels)
- [ ] Coronary artery disease
- [ ] Overweight or obesity
- [ ] Diabetes mellitus (“sugar diabetes”)
- [ ] Chronic Lung disease (e.g., asthma, COPD, emphysema)
- [ ] Neurological disease
- [ ] Kidney disease, chronic (not urinary tract infections)
- [ ] Hemodialysis
- [ ] Rheumatoid arthritis or other immunity-related disease
- [ ] Regular oral steroid use (e.g., prednisone, medrol)
- [ ] Sickle cell disease (not trait only), thalassemia, or other gene-related blood diseases
- [ ] Spleen disease
- [ ] Chronic liver disease (e.g., chronic-hepatitis, cirrhosis, jaundice)
- [ ] Sexually transmitted infections
- [ ] AIDS or HIV infection
- [ ] Low Immunity. If “yes,” check if:
  - [ ] HIV (CD4<200 cells/µL)
  - [ ] leukemia or lymphoma, recent bone marrow transplant
  - [ ] birth-related immune deficiency
  - [ ] cancer now or treatment with chemotherapy
  - [ ] radiation or long-term steroids (> 20 mg prednisone)
- [ ] Blood transfusion from 1978 to 1985
- [ ] Blood transfusions repeatedly
- [ ] Leaking of cerebrospinal fluid (liquid around the brain)
- [ ] After age 39, had any bone fracture due to little or no injury
- [ ] Other(s) ____________________________________________

For clinician’s consideration

<table>
<thead>
<tr>
<th>Other considerations, eg, vaccinations</th>
</tr>
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<tbody>
<tr>
<td>Lipid, DM screens, Counsel diet</td>
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<td>Lipid, DM screens, Counsel diet</td>
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<tr>
<td>DM screens, Counsel diet; FLU, PVX</td>
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<tr>
<td>Counsel diet; if BMI &gt; 30 intensive intervention</td>
</tr>
<tr>
<td>Lipid, glaucoma screens *; FLU, PVX</td>
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<tr>
<td>PVX</td>
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<tr>
<td>PVX</td>
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<tr>
<td>PVX</td>
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<tr>
<td>PVX, HBV</td>
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<td>PVX</td>
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<tr>
<td>PVX</td>
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<tr>
<td>PVX, Menactra</td>
</tr>
<tr>
<td>PVX, Menactra</td>
</tr>
<tr>
<td>PVX, HAV, HBV</td>
</tr>
<tr>
<td>Chlam, GC, HIV, Intensive STI counsel</td>
</tr>
<tr>
<td>PVX, HAV, HBV</td>
</tr>
</tbody>
</table>

**NO** live vaccines (Flumist, Herpes Zoster, Measles-Mumps-Rubella, Varicella)

<table>
<thead>
<tr>
<th>HIV</th>
<th>HAV, HBV</th>
<th>PVX</th>
</tr>
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</tbody>
</table>

Assess OP risk; DEXA scan ≥50y if high risk (BMI <20)
Surgery
☐ Cochlear implant(s) for hearing
☐ Hysterectomy
☐ Bone marrow or other organ transplant
☐ Splenectomy (surgical removal of the spleen)
☐ Other(s)_________________________

PVX
Cease cervical Ca screen if TAH and benign cause
PVX, Menactra, FLU-6 months after transplant), NO live vaccines, Menactra

Social History
☐ Freshman student living in a dorm
☐ College student
☐ Health care worker/student (nurse, doctor, dentist, etc)
☐ Will be with adoptee from country with hepatitis A, first 60 days here
☐ Work around individuals with low immune condition
☐ Other possible work exposure blood/body fluids (safety worker, etc)
☐ Work in laboratory with hepatitis A or neisseria meningitis

2nd MMR, Menactra
2nd MMR
2nd MMR, HBV
HAV
VZV
HBV
HAV or Menactra

Sexual Health
☐ Not started sexual activity
☐ Sexually active with male partner(s). If yes:
  ☐ Using birth control? If yes, method/type____________
  ☐ Sometimes have sex with men without condoms/barrier
☐ Sexually active with female partner(s)
☐ Sexual partner ever had sexually transmitted infection
☐ Started sex with new partner in the last year
☐ Had sex with more than one partner in the last year
☐ Current sex partner had other sex partner(s) in the last year
☐ Self or partner(s) was ever sex worker or in sexual exchange activity
☐ Desire HPV (human papilloma virus) vaccine
☐ Desire Hepatitis B vaccine
☐ Desire testing for HIV

HPV
HPV, Chlam (esp <24)
(Counsel on methods)
Chlam & GC (esp <25y); HIV, +/- Syph, Intensive STI counsel
Chlam & GC (esp <25y); HIV, +/- Syph, Intensive STI counsel
Chlam & GC (esp <25y); HIV, +/- Syph, Intensive STI counsel
Chlam, GC (esp <25y); HBV, HIV, +/- Syph, Intensive STI counsel
Chlam, GC, Syph, HIV, Intensive STI counsel
<27y, HPV
HBV
HIV
Consider chlam & GC community prevalence

Mood
☐ Over the past 2 weeks have you felt down, depressed or hopeless?
☐ Over the past 2 weeks have you felt little interest or pleasure in doing things?

Counsel
Domestic concerns
☐ Are you afraid of anyone close to you?
☐ Have you ever been hit, slapped, kicked, pushed or shoved or other-
wise physically hurt by your partner or someone close to you?
☐ Are you frequently upset, ashamed or embarrassed by someone
close to you?
☐ Has anyone forced you to have sexual activities?

Exercise, Diet, and Alcohol
____ Number days you exercise per week
____ Number of minutes you exercise on days that you exercise
____ Number of servings (1/2 cup each) of fruit & vegetables you eat daily
☐ Not taking calcium supplement
☐ Not taking vitamin D supplement
☐ Drank alcohol in the past year. If “yes”:
  Types used: ☐ beer ☐ wine ☐ liquor ☐ other
  ____ Number of drinks per day
  ____ Number of drinks per week
  ____ Most drinks per day during the past year
☐ Have you ever felt you should cut down on drinking
☐ Have people annoyed you by criticizing your drinking
☐ Have you ever felt bad or guilty about your drinking
☐ Have you ever had a drink first thing in the morning to steady
  your nerves or get rid of a hangover?

Tobacco and Substance Use
☐ Used tobacco in the past year. If “yes”:
  Types used: ☐ cigarettes ☐ cigars ☐ pipe ☐ smokeless ☐ chew
  ☐ Want to quit smoking/using tobacco?
☐ Injected recreational drug use (e.g., heroin) ever. Please list drugs
  injected: ________________________________

Age-Related Preventive Screening
☐ Age is 18 or older?
☐ Age is 26 or younger?
☐ Age is 21 or older? If yes:
  ☐ Ever had Pap smear? If yes:
    Date last Pap Smear _________
  ☐ Ever had abnormal Pap smear?
  ☐ Age is 65 or older? If yes:
    ☐ Abnormal Pap test in last 10 years?
    ☐ Had less than 3 Pap tests in your life?
    ☐ New sexual partner in last three years?
**Mammography Shared Decision Making**

- Age is from 40 to 49?
  - Last mammogram: □ never or date ___________
  - □ Checked/screened for colon cancer. If “yes,” for most recent:
    - Date: __________
    - Type: □ stool blood test □ flexible sigmoidoscopy □ colonoscopy □ barium enema
    - □ Any polyps found

- Age is from 50 to 75?
  - □ CRC q 1-10y by screen type

**Counsel**
- □ Mammog q 2y

**Counsel**
- □ CRC

**Counsel**
- □ HZV

**OP: DEXA scan all ≥ 65y; PNV, FLU high dose?**
- □ Hearing test
- □ Bone densitometry

**Immunizations and Preventable Infections**

- □ Tetanus vaccine—Date most recent? __________
- □ Health care worker
- □ Care provider to child <1 year old
- □ Influenza vaccine—Date most recent? __________
- □ Pneumovax vaccine—Date most recent? __________
- □ Herpes Zoster vaccine—Date? __________
- □ Hepatitis B vaccine (series of 3)—Dates? _______ _______ _______
- □ Hepatitis A vaccine (series of 2)—Dates? _______ _______
- □ Human papilloma virus vaccine (series of 3)—Dates? _______ _______
- □ Chicken pox infection or □ chicken pox vaccine
- □ Rubella infection or □ rubella vaccine—Date? __________
- □ Measles infection or □ measles vaccine—Date? __________

**Breast Cancer Risk Assessment**

- □ 35 year or older now
- □ Known/suspected genetic mutation, BRCA1, BRCA 2, p53 or PTEN
- □ Mother or sister had breast cancer
- □ You started having periods before you were 12 years old
- □ You stopped having periods after the age of 55
- □ Never had children
- □ First child after age 30
- □ Breast disease other than breast cancer
- □ Pre-cancerous breast problems (proliferative, atypical hyperplasia)
- □ Used hormone replacement therapy (HRT) more than four years
- □ Exposed to chest radiation

- □ 5 yr risk 1.7%, BrC chemoprev counsel

**Genetics Counsel**
- □ Assess Risk Fully

**Assess Risk Fully**
- □ Assess Risk Fully

**Assess Risk Fully**
- □ Assess Risk Fully

**Assess Risk Fully**
- □ Assess Risk Fully

**Assess Risk Fully**
- □ Assess Risk Fully
Family History: Please circle any condition appearing below that has affected any blood relative.

- Mother or sister after age 49 had bone fracture of wrist, hip or spine
- Breast cancer? If yes: who & age at onset ___________________ Assess; DEXA scan ≥ 60 if high risk Genetic Couns, CRC risk
- Ovarian cancer? If yes: who & age at onset ___________________ Genetic Couns, CRC risk
- Colon cancer? If yes: who & age at onset ___________________ BrCa, OvCa, CRC risk
- Heart attack? If yes: who & age at onset ___________________ CAD risk
- Diabetes Mellitus? If yes: who & age at onset ___________________ CAD risk
- Glaucoma in family member
- Family member to get organ transplant in next 6 months
- Family member is person with hepatitis B infection
- Family member, other medical condition? ____________________

Special Considerations

- Living in nursing home or long-term care facility
- Ever in correctional facility
- African American ancestry and age 50 or older
- Hispanic American ancestry and age 50 or older
- Exposed to mumps or measles outbreak?

Review of Systems • Which of the following affect you? Circle responses.

<table>
<thead>
<tr>
<th>General</th>
<th>fever</th>
<th>decreased/no energy</th>
<th>loss appetite</th>
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<th>none</th>
</tr>
</thead>
<tbody>
<tr>
<td>Head</td>
<td>headache</td>
<td>injury</td>
<td></td>
<td></td>
<td>none</td>
</tr>
<tr>
<td>Eye</td>
<td>visual change</td>
<td>crossed</td>
<td>discharge</td>
<td>redness</td>
<td>puffiness</td>
</tr>
<tr>
<td>Ear</td>
<td>difficulty with hearing</td>
<td>pain</td>
<td>discharge</td>
<td></td>
<td>none</td>
</tr>
<tr>
<td>Nose</td>
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<td>nasal congestion</td>
<td>nose bleed</td>
<td></td>
<td>none</td>
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<tr>
<td>Mouth/throat</td>
<td>sore throat</td>
<td>difficulty swallowing</td>
<td>dental problems</td>
<td></td>
<td>none</td>
</tr>
<tr>
<td>Lung</td>
<td>shortness of breath</td>
<td>coughing</td>
<td>chest pain</td>
<td>wheezing</td>
<td>sputum</td>
</tr>
<tr>
<td>Heart</td>
<td>pale</td>
<td>cyanosis</td>
<td>chest pain</td>
<td>leg swelling</td>
<td>faint</td>
</tr>
<tr>
<td>Gastrointestinal</td>
<td>distention</td>
<td>blood in stool</td>
<td>black/tarry stool</td>
<td></td>
<td>none</td>
</tr>
<tr>
<td>Genitourinary</td>
<td>painful urination</td>
<td>urine retention</td>
<td>incontinence</td>
<td>difficulty urinating</td>
<td>none</td>
</tr>
<tr>
<td>Musculoskeletal</td>
<td>deformities</td>
<td>joint pain</td>
<td>joint swelling</td>
<td>difficulty in moving</td>
<td>none</td>
</tr>
<tr>
<td>Neurologic</td>
<td>dizziness</td>
<td>weakness</td>
<td>hand shakiness</td>
<td>seizures</td>
<td>none</td>
</tr>
<tr>
<td>Skin</td>
<td>rash</td>
<td>itching</td>
<td>color change</td>
<td>easy bruising/bleeding</td>
<td>change in mole</td>
</tr>
<tr>
<td>Psychiatric</td>
<td>frequent mood change</td>
<td>nervousness</td>
<td>tension</td>
<td>feeling down</td>
<td>none</td>
</tr>
</tbody>
</table>

* Not in USPSTF