



Patient Name: \_\_\_\_\_

Gender :            Male                                  Female                                  Report Date : \_\_\_\_\_

Medicare Number \_\_\_\_\_

Date of Effective Date Part A: \_\_\_\_\_ Date of Effective Date of Part B: \_\_\_\_\_

**1. One time Welcome to Medicare Preventive Visit Exam**

YES                  NO

Have you had your Welcome to Medicare Exam?

☐☐

If Yes , Date: \_\_\_\_\_

**2. Yearly Wellness Visit**

YES                  NO

Have you had your Medicare yearly Wellness visit exam taken?

☐☐

If Yes , Date: \_\_\_\_\_

**3. Cardiovascular Screening**

YES                  NO

Have you had a test for cholesterol, lipid and triglyceride levels done?

☐☐

If Yes , Date: \_\_\_\_\_

**4. Colorectal Cancer Screening**

YES                  NO

Have you ever had the following exams done?

Fecal Ocult Blood Test            If Yes, Date \_\_\_\_\_

☐☐

Flexible Sigmoidoscopy            If Yes, Date \_\_\_\_\_

☐☐

Colonoscopy                          If Yes, Date \_\_\_\_\_

☐☐

Barium Enema                        If Yes, Date \_\_\_\_\_

☐☐

Are you at risk of colorectal cancer? Answer the following questions:

A. Have you had colorectal cancer before, even if it has been completely removed?

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B. Do you have a close relative, (brother, sister, parent or child), who had colorectal polyps or colorectal cancer?

☐☐

C. Do you have a history of polyps?

☐☐

D. Do you presently have any inflammatory bowel disease, like ulcerative colitis or Chrohn's disease?

☐☐

**5. Bone Mass Measurement****YES****NO**

Have you ever had a Bone Mass Measurement test done?

☐☐

If Yes, Date \_\_\_\_\_

Are you at risk for osteoporosis? Answer the following questions:

E. Have you had any vertebral abnormalities, as demonstrated by an X-ray?

☐☐

F. Have you received steroid treatments?

☐☐

G. Have you ever been diagnosed with hyperparathyroidism?

☐☐

H. Have you ever taken or are you presently taking any osteoporosis medication?

☐☐

I. (Only for female) Has your doctor ever mentioned to you that you are estrogen-deficient and that you might be at risk for osteoporosis?

☐☐**6. Abdominal Aortic Aneurism****YES****NO**

Have you ever had an abdominal aortic aneurysm screening done?

☐☐

If Yes, Date \_\_\_\_\_

Are you at risk for Abdominal Aortic Aneurism? Answer the following questions:

J. Do you have a family history of Abdominal Aortic Aneurism?

☐☐

K. Have you smoked more than 100 cigarettes in your life?

☐☐**7. Diabetes****YES****NO**

Have you ever had a Diabetes screening done?

☐☐

If Yes, Date \_\_\_\_\_

L. Have you been diagnosed with Diabetes?

☐☐

M. Do you have High Blood Pressure, dyslipidemia (history of abnormal cholesterol and triglyceride levels), obesity, or history of high blood sugar (glucose)?

☐☐

N. Are you overweight, or do you have a family history of diabetes (parents, brothers, or sisters)?

☐☐

O. (Female Only) Do you have a history of gestational diabetes (diabetes during pregnancy), or had you had a baby weighing over 9 pounds?

☐☐

**8. Medical Nutrition Therapy****YES****NO**

Have you ever received medical Nutrition Therapy? If Yes, Date: \_\_\_\_\_

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P. Do you presently have renal disease (people with kidney disease, but not on dialysis)?

☐☐

Q. Have you had a kidney transplant within the last three years?

☐☐**9. Shots – Flu****YES****NO**Are you under 65 with any one of the following conditions?

R. Heart disease?

☐☐

S. Lung disease?

☐☐

T. Diabetes?

☐☐

U. End Stage Renal Disease?

☐☐**10. Shots – Hepatitis B****YES****NO**

Are you at medium or high risk for Hepatitis B? Have you been diagnosed with:

V. Hemophilia?

☐☐

W. End Stage Renal Disease?

☐☐

X. Do you live with someone who has Hepatitis B?

☐☐

Y. Are you a healthcare worker in contact with blood or body fluids?

☐☐**11. Glaucoma Test****YES****NO**

Have you ever had a Glaucoma Test done? If Yes, Date: \_\_\_\_\_

☐☐

Are you at high risk for Glaucoma? Answer the following:

Z. Do you have diabetes?

☐☐

AA. Do you have a family history of glaucoma?

☐☐

AB. Are you African American and age 50 or older?

☐☐

AC. Are you Hispanic and age 65 and older?

☐☐

**12. Tobacco Use Cessation Counseling**

YES

NO

Have you ever had Tobacco Use Cessation Counseling? If Yes, Date: \_\_\_\_\_

☐☐

AD. Do you smoke?

☐☐**13. Breast Cancer Screening ( Mammograms)**

YES

NO

Have you ever had a Breast Cancer Screening? If Yes, Date: \_\_\_\_\_

☐☐

Are you at high risk for Brest Cancer? Answer the following questions:

AF. Are you over the age of 40?

☐☐

AG. Have you had breast cancer in the past?

☐☐

AH. Do you have a family history of breast cancer (like mother, sister, daughter, or two or more close relatives who have had breast cancer)?

☐☐

AI. Did you have your first baby after the age of 30?

☐☐

AJ. Have you ever had a baby?

☐☐**14. Cervical and Vaginal Cancer Screening**

YES

NO

Have you ever had a cervical and vaginal cancer screening? If Yes, Date: \_\_\_\_\_

☐☐

Are you at high risk for cervical cancer? Answer the following questions:

AK. Have you had an abnormal Pap Test?

☐☐

AL. Have you had cervical or vaginal cancer in the past?

☐☐

AM. Have you had a history of sexually transmitted disease (including HIV infection)?

☐☐

AN. Did You began having sex before age 16?

☐☐

AO. Have you had many sexual partners?

☐☐

AP. Do you know if your mother took DES (Diethylstilbestrol), a hormonal drug, when she was pregnant with you?

☐☐**15. Prostate Cancer Screening**

YES

NO

Have you ever had a Prostate Cancer Screening, including Digital Rectal Examination and PSA Test? If Yes, Date: \_\_\_\_\_

☐☐

AQ. Are you over 50?

☐☐

Are you at high risk for Prostate cancer? Answer the following questions:

AR. Do you have a father, brother or son who has had prostate cancer, especially if your relatives were young when they got the disease?

☐☐

AS. Are you African American?

☐☐

AT. Do you eat a lot of read met or high fat dairy products?

☐☐



## 5 Year Roadmap to Preventive Services

Beneficiary Name: \_\_\_\_\_

Date of Report: \_\_\_\_\_

Medicare Covered Preventive Service	2012	2013	2014	2015	2016
Welcome to Medicare Preventive Visit					
Yearly Wellness Visit					
Abdominal Aortic Aneurism Screening					
Bone Mass Measurement					
Cardiovascular Screening					
Colorectal Cancer Screening					
Fecal Occult Blood Test					
Flexible Sigmoidoscopy					
Colonoscopy					
Barium Enema					
Diabetes Screening					
Diabetes Self-Management Training					
Flu Shots					
Glaucoma Test					
Hepatitis B Shots					
HIV Screening					
Mammogram Screening					
Medical Nutrition Therapy Services					
Pap Test, Pelvic Exam and Breast Exam					
Pneumococcal Shot					
Prostate Cancer Screening					
Tobacco Use Cessation Counseling					



## 5 Year Roadmap to Preventive Services

Medicare Covered Preventive Service	You Need It (Yes/No)	Last Received	Up-to-date (Yes/No)	Next Date Medicare covers this service
Welcome to Medicare Preventive Visit				
Yearly Wellness Visit				
Abdominal Aortic Aneurism Screening				
Bone Mass Measurement				
Cardiovascular Screening				
Colorectal Cancer Screening				
Fecal Occult Blood Test				
Flexible Sigmoidoscopy				
Colonoscopy				
Barium Enema				
Diabetes Screening				
Diabetes Self-Management Training				
Flu Shoots				
Glaucoma Test				
Hepatitis B Shots				
HIV Screening				
Mammogram Screening				
Medical Nutrition Therapy Services				
Pap Test, Pelvic Exam and Breast Exam				
Pneumococcal Shot				
Prostate Cancer Screening				
Tobacco Use Cessation Counseling				