Patient Questionnaire

Name: _____

Date of Birth: _____

1. Have you had a pneumonia vaccination? (Please Circle)

YES **NO**

If yes, type of pneumonia vaccination received? (Please Circle)

Pneumovax Prevnar

Date/ Location: _____

2. If you are between the age of 50-75, have you had any of the following: (Please Check all that apply and list date and location if applicable)

☐ Colonoscopy in the last 9 years _____

☐ Stool testing for hidden blood in the last 2 years_____

☐ Cologuard _____

3. If you are over the age of 65, have you had any fall related injuries recently? (Please Circle)

YES **NO**

Date/ Location: _____

☐ Are you afraid of falling?