Regional Primary Care, Inc.
150 S. Mt. Auburn Rd., Ste. 418
Cape Girardeau, MO 63703
(573)332-6000

Recommended Adult Preventative Services Form

This document is part of your permanent record.

Name: _____ DOB: _____ Today's Date: _____

Are you a Medicare Patient? ☐ Yes ☐ No Effective Date: _____

DEPRESSION SCREENING

1. Over the past two weeks has the patient felt down, depressed, or hopeless? ☐ Yes ☐ No
2. Over the past two weeks has the patient felt little interest or pleasure in doing things? ☐ Yes ☐ No

EVALUATION OF COGNITIVE FUNCTION

Describe Mood/Affect: _____
Family Member/Caregiver Input: _____

FUNCTIONAL ABILITY/SAFETY SCREENING

1. Does the patient need help with the phone, transportation, shopping, preparing meals, housework, laundry, medications, or managing money? ☐ Yes ☐ No
2. Does the patient's home have rugs in the hallway, lack of grab bars in The bathroom, lack of handrails on the stairs, or have poor lighting? ☐ Yes ☐ No
3. Has the patient noticed any hearing difficulties? ☐ Yes ☐ No
4. Has the patient noticed any vision difficulties? ☐ Yes ☐ No

VACCINES:

Test	Approximate Date	Ordering Provider	Where was test performed
Pneumococcal Vaccine			
Influenza Vaccine			
Shingles Vaccine			
Hepatitis B Vaccine			
TD Vaccine (Tetanus) 10 years			
MMR Vaccine			
Meningococcal Vaccine			
Hepatitis A Vaccine			

INITIAL _____

TESTS:

Test	Approximate Date	Ordering Provider	Where was test performed
Mammogram (Annual)			
Pap and Pelvic (Biennial except high risk)			
Prostate Cancer Screening DRE/PSA (Annual)			
Colorectal Cancer Screening			
Diabetes Self-Management Training			
Diabetic Screening Test FBS or GTT			
Bone Density Exam			
Hearing Screening			
Vision Screening			
Glaucoma Screening			
Cardiovascular Screening Cholesterol testing			
Abdominal Aortic Aneurysm Screening			
Most Recent Annual Wellness Exam			

INITIAL _____