FOR MEDICARE PATIENTS ONLY (for screening colonoscopy only)

MEDICARE PQRS DATA FORM

Patient Name_________________________________ Date of Birth________ Date________

The doctors at Digestive Disease Center are committed to providing their patients with the highest quality of care. The data we are requesting below is required for submission to the Centers for Medicare Services to demonstrate our dedication and concern for your well being.

Height:_________ Weight:_________

Smoking status: Current every day Former Never

Alcohol use: Current every day Occasionally Never Quantity_________

Adults aged 50 and older: Have you ever had a colonoscopy? Yes No If yes, when?

Adults aged 50 and older: Did you receive a flu shot during this past flu season? Yes No

Adults aged 65 and older: Did you ever receive a pneumonia vaccine? Yes No

FEMALE Patients Only:

Women aged 50 through 69: Have you had a mammogram within the last 2 years?

Women aged 65 and older: Have you been screened or have had therapy for Osteoporosis? __________________________

Women aged 65 and older: Have you been assessed for Urinary Incontinence within the past 12 months? _______________________

Patient/Guardian Signature ____________________________

Dp 08/14