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

**55 years of age and older – Have you received a pneumococcal vaccine in the past 10 years?**

- Yes – What year?
- No

**65 years of age and older – Have you fallen in the last three months?**

- Yes
- No

**65 years of age and older – have you received a colonoscopy in the past 10 years?**

- Yes – What year?
- No