ANDROS ENT
EAR NOSE THROAT & SLEEP CENTER
My Kind of Care

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