Patient Last Name: _____Patient First Name:_____DOB_____

Preventative Service History

Preventative Services	Date	
Bone Mass Measurement (Density) Fracture: Yes NO	_____	What Part of your body did you fracture?
Cardiovascular Disease Screening: Cholesterol>>>>>>>>>>>>>>>>> LDL>>>>>>>>>>>>>>>>>>>>>>>> EKG>>>>>>>>>>>>>>>>>>>>>	_____ _____ _____	Do you exercise regularly? Yes__No__ Have you fallen in the last 12 months? Yes__ No___ Do you frequently lose your balance or feel dizzy? Yes__ No__ Bladder Control Problem? Yes__No__
Diabetes Screening HgA1C>>>>>>>>>>>>>>>>> Foot Exam>>>>>>>>>>>>>>>>>>> Eye Exam>>>>>>>>>>>>>>>>>	_____ _____	Cataracts____ Other _____
Colorectal Cancer Screening Flexible Sigmoidoscopy>>>>> Colonoscopy (not high risk)>>>> Fecal Occult Blood Test>>>>>	_____ _____ _____	
Glaucoma Screening	_____	Glaucoma Yes__No__
PAP and Pelvic Exam		
Prostate Cancer Screening Digital Rectal Exam (DRE) Prostate Specific Antigen (PSA)		
Mammogram Screening Mammogram		
Alcohol Screening Tobacco Screening Pneumonia Vaccine Influenza Vaccine Sexual History Depression Screening		

Signature: _____Date: _____