

Date: _____

Patient Name: _____ **DOB :** _____

Health Maintenance Checklist

TEST	DATE	PLACE/DOCTOR
<p>Mammogram Women 40yo and older annual</p>		
<p>Colorectal Cancer Screening (Please circle) Colonoscopy Sigmoidoscopy Stool testing – Please indicate which one. Age 50 and older. Repeat interval determined by provider</p>		
<p>Bone Density Women age 65yo Repeat interval determined by provider</p>		
<p>Pap smear Women 21-65yo every 3 years (or interval per GYN)</p>		
<p>Eye Exam Diabetics annual Glaucoma screen</p>		
<p>Recent Immunizations</p>	<p>Flu: Pneumococcal: Pevnar: Shingles: Shingrix: Tetanus: Tdap:</p>	
<p>Living Will or Advanced Directive</p>		<p>If you have one please bring a copy to your visit</p>

Please provide a copy of result if possible.