PREVENTATIVE CARE / HEALTH MAINTENANCE

LAST FULL PHYSICAL: DATE_____ NEVER? _____

LAST COLONOSCOPY: DATE_____ FACILITY/DOCTOR'S NAME: _____

VACCINATIONS:

LAST TETANUS? Date __/___/___ >5-10 yrs.____ PNEUMONIA? Date __/___/___ >5-10 yrs.____

HEPATITUS B SERIES (3)? Yes___ (Date_____) No ___

SHINGLES/Zostavax? Date ___/___/___ Never_____ I had the disease YES ( ) ___/___/___ NO ( )

FEMALES ONLY:

LAST MAMMOGRAM: DATE _____ NEVER? _____ FACILITY NAME: _____

GYNECOLOGIST NAME: _____NEED RECOMMENDAT'N? ( ) Yes ( ) NO

MEN ONLY:

LAST PROSTATE EXAM DATE ___/___/___ PSA BLOOD TEST DATE: ___/___/___ Never ( )

PREFERRED PHARMACIES FOR ORDERED PRESCRIPTIONS:

RETAIL PHARMACY #1:_____LOCATION:_____

RETAIL PHARMACY #2:_____LOCATION:_____

ONLINE PHARMACY: _____LOCATION:_____

WOULD YOU LIKE TO HAVE YOUR OLD RECORDS TRANSFERRED TO OUR OFFICE? ( ) YES ( ) NO

Provider's or Group Name: _____

Address: _____

_____City_____ State_____ Zip _____