

Adult Preventive Care Flow Sheet

Patient Name: _____ Patient #: _____

Allergies/Adverse Reactions: _____ Patient Date of Birth: _____

Date: _____

Screening:

Height	<i>Annually</i>								
Weight									
BMI Value									
Hearing/Vision									
Tobacco Use: Y / N									
Instructed to Quit: Y/N									
ETOH Use: Y / N									
Fall Risk/Functional Assessment/ADL's									
Pain Screening 1-10									
Urinary Incontinence/Frequency									
Depression									
DEXA scan/Meds FEMALES OVER 65									

Laboratory/Diagnostics:

LIPIDS- Result: _____

<u>Diabetes Screening :</u> HbA1c Dilated Retinal Eye Exam Monitor DM Nephropathy	<i>Annually</i>								
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Pap Smear/Pelvic	<i>1-3 yrs</i>								
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Mammogram	<i>≥ 40 every 1-2 yrs</i>								
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<u>Colorectal Screening :</u> (one of following):	<i>>50</i>								
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FOB/FIT	<i>Annually</i>								
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Flex sigmoidoscopy	<i>Every 5 yrs</i>								
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Colonoscopy	<i>Every 10 yrs</i>								
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Counseling :

Nutrition/Exercise _____

Drug Abuse/Screening	<i>Every well visit/PRN</i>								
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Review of Meds/Contraindications									
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Living Will/Advanced Directives/POA-Annually									
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Immunizations:

Tetanus and Diphtheria (Td)/Tdap	<i>Every 10 yrs</i>								
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Pneumo Vaccine at risk / > 65 yrs _____

Influenza at risk / > 50 yrs	<i>Annually</i>								
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Hepatitis B									
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Herpes Zoster/Shingles vaccine									
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