ADULT GENERAL PREVENTION FLOW SHEET

PATIENT: _____ **D.O.B.:** _____ **MR#:** _____
PROVIDER: _____ **HEIGHT:** _____

	EXAM/TEST	***Date:***										
EVERY VISIT	**Weight/BMI**[1] Goal BMI<25	Value										
	Blood pressure[2] Systolic<140; Diastolic<90	Value										

	EXAM/TEST	***Year performed:***	***20___***		***20___***		***20___***		***20___***		***20___***	
YEARLY	**Clinical breast exam**[3]**/ prostate exam**[4]	Date (circle exam)										
	PAP[5]**/PSA**[4] (circle exam)	Date/result										
	Mammogram[3]	Date/result										
	Fecal occult blood test[6]	Date/result										
	Aspirin therapy[7] (✓ if taking)	Date										
	Flu vaccine[8] (if indicated)	Date										
	Hearing screening[9]	Date										
	Tobacco use screening/ counseling[10]	Date										
	Alcohol misuse screening[11]	Date										
	Depression screening[12]	Date										
	Fall risk screening[13]	Date										
	Dietary counseling or referral for patients with hyperlipidemia or other risk for diet-related chronic disease[14]	Date										

PERIODICALLY	**Lipid screening**[15]	Date/result										
	Diabetes screening[16]	Date/result										
	Eye exam referral[17]	Date										
	Pneumococcal vaccine[18]	Date			**Td** Date			**EKG**[19] Date				
	Bone densitometry[20]	Date					**Sigmoidoscopy/ colonoscopy**[21] Date					

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See page 2 for additional information on the numbered items.