Name
D.O.B.
No.

Adult Preventive Care Flow Sheet

PUT PREVENTION INTO PRACTICE

ALLERGIES:

Health Counseling

(Circle if appropriate)

1. Alcohol and Drugs
2. Aspirin
3. Dental and Oral Health
4. Hormone Replacement Therapy
5. Domestic Violence
6. Family Planning
7. Folate
8. Injuries (e.g. seat belts, falls)
9. Nutrition
10. Occupational Health
11. Osteoporosis
12. Physical Activity
13. Polypharmacy
14. Self-Exams (skin, breast, testicular)
15. STDs/HIV Infection
16. Tobacco
17. _____
18. _____

Date									
Type(s)									
Date									
Type(s)									
Date									
Type(s)									
Date									
Type(s)									
Date									
Type(s)									
Date									
Type(s)									

Screening and Tests

Suggested Examinations and Tests:*

Blood Pressure
Breast Exam
Cholesterol
Cognitive and Functional Impairment
Depression
Digital Rectal Exam
Fecal Occult Blood
Glaucoma
Hearing
Height/Weight
Mammography
Oral Cavity Exam
Pap Smear/Pelvic Exam
Plasma Glucose
Prostate Exam/PSA
Sigmoidoscopy
Skin Exam
Testicular Exam
Thyroid Function/Exam
Tuberculin Skin Testing
Urinalysis
Vision

** Specific preventive protocols should be tailored to the patient's risk factors and based on discussion between the patient and provider*

Examinations and Tests	Schedule										
		Date									
		Result									
		Date									
		Result									
		Date									
		Result									
		Date									
		Result									
		Date									
		Result									
		Date									
		Result									

Immunizations

Immunization/Frequency

Influenza ≥ 65 YRS. OR IMMUNOCOMPROMISED YEARLY	**Date**											
	Manuf. & Lot No.											

Pneumococcal ≥ 65 YRS. OR IMMUNOCOMPROMISED ONE DOSE	**Date**			**Tetanus and Diphtheria** ALL ADULTS EVERY 10 YEARS	**Date**				**Date**	
	Manuf. & Lot No.				Manuf. & Lot No.				Manuf. & Lot No.	
Varicella NON-IMMUNE ADULTS TWO DOSES DELIVERED 4-8 WEEKS APART IF IMMUNIZED AFTER AGE 13 YEARS	**Date**			**Rubella** WOMEN OF CHILDBEARING AGE AND HEALTH CARE WORKERS WITHOUT EVIDENCE OF IMMUNITY OR PRIOR IMMUNIZATION ONE DOSE	**Date**				**Date**	
	Manuf. & Lot No.				Manuf. & Lot No.				Manuf. & Lot No.	
Hepatitis B ADULTS AT INCREASED RISK 3 OR 4 DOSE SERIES	**Date**								**Date**	
	Manuf. & Lot No.								Manuf. & Lot No.	

Other Immunizations

	Date	
	Manuf. & Lot No.	
	Date	
	Manuf. & Lot No.	
	Date	
	Manuf. & Lot No.	
	Date	
	Manuf. & Lot No.	
	Date	
	Manuf. & Lot No.	
	Date	
	Manuf. & Lot No.	