INTERNAL MEDICINE & FAMILY PRACTICE, SC

SCREENING HISTORY:

COLONOSCOPY **Y / N** IF YES, DATE & FACILITY: _____

FECAL OCCULT X3 **Y / N** IF YES, DATE & FACILITY: _____

DNA FECAL TESTING **Y / N** IF YES, DATE & FACLITY: _____

TUBERCULOSIS TEST **Y / N** IF YES, DATE: _____

MAMMOGRAM **Y / N** IF YES, DATE & FACILITY: _____

PAP SMEAR/PELVIC EXAM **Y / N** IF YES, DATE/AGE: _____

VACCINE HISTORY

FLU VACCINE **Y / N** IF YES, DATE & FACILITY: _____

(PNEUMONIA) VACCINE **Y / N** IF YES, DATE AND FACILIY: _____
PREVNAR

TETINUS **Y / N** IF YES, DATE & FACILITY: _____

SHINGLES VACCINE **Y / N** IF YES, DATE & FACILITY: _____

HPV **Y / N** IF YES, DATE & FACILITY: _____

I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE. I WILL NOT HOLD MY MEDICAL PROVIDER OR ANY MEMBER OF HIS/HER STAFF RESPONSIBLE FOR ANY ERRORS OR OMISSIONS THAT I MAY HAVE MADE IN THE COMPLETION OF THIS FORM.

PATIENT SIGNATURE: _____ **DATE:** _____