SUBURBAN HEALTHCARE ASSOCIATES
HEALTH MAINTENANCE RECOMMENDATIONS

PATIENTS NAME: ____ **AGE:** ______________________

FOR YOUR HEALTH MAINTENANCE WE RECOMMEND THAT THE FOLLOWING PROCEDURES BE DONE REGULARLY. THESE ARE ONLY GUIDELINES AND ARE NOT COMPLETE OR EXHAUSTIVE. THE PHYSICIAN WILL DISCUSS ANY OTHER REQUIREMENTS AT THE TIME OF THE VISIT.

FEMALES

MAMMOGRAM: DONE ON______________________ FAMILY HX_____________________

DUE__________ ABNORMAL NORMAL NOT NEEDED REFUSED

PAP SMEAR: DONE ON____________________________ DUE________________________________

ABNORMAL NORMAL NOT NEEDED REFUSED HISTORY OF HPV

MALES

PROSTATE SCREEN: DONE ON__________________________ DUE_________________________

ABNORMAL NORMAL NOT NEEDED REFUSED

CHEST XRAY: DONE ON__________________________ DUE_________________________

ABNORMAL NORMAL NOT NEEDED REFUSED

DEPRESSION SCREEN: DONE ON___________________________ DUE________________________

ABNORMAL NORMAL NOT NEEDED REFUSED DENIES SYMPTOMS

COLONOSCOPY: DONE ON___________________________ DUE________________________

ABNORMAL NORMAL NOT NEEDED REFUSED

I HAVE READ AND UNDERSTAND THE ABOVE GUIDELINES TO ENSURE THE BEST TREATMENT AND AGREE TO DO WHAT IS NEEDED TO BE COMPLIANT.

PATIENT SIGNATURE: ____ DATE: _______________________

M.A. SIGNATURE: ____

M.D., P.A., N.P. SIGNATURE: _______________________________________