

**Yearly Physical****Form**

Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Date: \_\_\_\_\_

\_\_\_\_\_

To the best of your ability, please let us know when these procedures were last done:

TEST NAME	YES/NO And date last preformed
<b>Physical/blood work</b> Yearly	Yes No Date of last exam: _____ N/A
<b>Mammogram</b> Average risk- every 2 years from age 50-74. May start earlier and re-screen more frequently if at elevated risk due to personal or family history of breast, ovarian, or cervical cancer	Yes No Date of last exam: _____ N/A
<b>Pap smear</b> Women age 12-30: cytology every 3 years Women aged 30-65: cytology every 3 years or cytology & HPV testing every 5 years	Yes No Date of last exam: _____ N/A
<b>Colonoscopy</b> At least once every 10 years starting at age 50 and ending at age 75	Yes No Date of last exam: _____ N/A
<b>Bone Density Scan</b> Women- starting at age 65 for most, age 60 if <150 pounds or at risk (fractures, etc) Repeat: every 2 years if results between -2 and -2.5 Every 3-5 years if results between -1.5 and -1.9 Every 10 years if results between -1 and 1.49	Yes No Date of last exam: _____ N/A
<b>Shingles vaccine</b> 1 dose after the age of 60 (even if you've had shingles)	Yes No Date of last vaccine: _____ N/A
<b>Tetanus booster</b> TDaP at least once, Td/booster every 10 years	Yes No Date of last vaccine: _____ N/A
<b>Pneumonia vaccine</b> 1 dose after age 65 May do 1 dose between ages 19-65 in adults who smoke or have asthma	Yes No Date of last vaccine: _____ N/A
<b>Influenza vaccine</b> Yearly	Yes No Date of last vaccine: _____ N/A

<p style="text-align: center;"><b>HPV Vaccine</b> 3 doses between the ages of 9 &amp; 26</p>	<p style="text-align: center;">Yes    No Date of last vaccine: _____ N/A</p>
<p style="text-align: center;"><b>Glaucoma Screening</b> Every 2 years if last exam was normal starting at 65</p>	<p style="text-align: center;">Yes    No Date of last eye exam: _____ N/A</p>

**Patients with Diabetes**

<p style="text-align: center;"><b>DILATED eye exam</b> Every 2 years if normal exam, yearly if abnormal</p>	<p style="text-align: center;">Yes    No Date of last exam: _____ N/A</p>
<p style="text-align: center;"><b>Foot Exam</b> Yearly</p>	<p style="text-align: center;">Yes    No Date of last exam: _____ N/A</p>
<p style="text-align: center;"><b>Lab testing including A1C</b> Every 3-6 months</p>	<p style="text-align: center;">Yes    No Date of last exam: _____ N/A</p>
<p style="text-align: center;"><b>Urine Micro albumin</b> Yearly</p>	<p style="text-align: center;">Yes    No Date of last exam: _____ N/A</p>

Are you a smoker? YES (current or previous) NO

How many packs per day? \_\_\_\_\_

Would you like information on smoking cessation? \_\_\_\_\_

If you are a smoker, when was your last Chest Xray or Chest CT?

\_\_\_\_\_