

Health Screening Checklist

Patient Name: _____ DOB: _____

Test/Screening	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Comments
Complete Physical											
Body Mass Index											
Blood Pressure											
Labs:											
Cholesterol, LDL	___	___	___	___	___	___	___	___	___	___	
FBS	___	___	___	___	___	___	___	___	___	___	
HbA1c	___	___	___	___	___	___	___	___	___	___	
HCT/HGB	___	___	___	___	___	___	___	___	___	___	
Urine Screen	___	___	___	___	___	___	___	___	___	___	
Vision											
Immunizations:											
Flu Vaccine	___	___	___	___	___	___	___	___	___	___	
Tetanus	___	___	___	___	___	___	___	___	___	___	
Pneumococcal	___	___	___	___	___	___	___	___	___	___	
Hepatitis B	___	___	___	___	___	___	___	___	___	___	
Depression Screen											
FOBT/FIT											
Sigmoidoscopy											
Colonoscopy											
Women											
Pap/Chlamydia											
Mammogram											
Clinical Breast Exam											
Breast Self Exam Ed											
Bone Density											
Men											
Prostate/Exam											
PSA											
Testicular Self Exam Education											

Note: A Body Mass Index Table is available on line at http://www.nhlbi.nih.gov/guidelines/obesity/bmi_tbl.htm
 Sources: National Institute of Mental Health, American College of Obstetricians and Gynecologists, and the American Cancer Society