

*This checklist is designed to help you get the right preventive healthcare and give you more control over your care.
Please share this checklist with your doctor at every visit. Your doctor can help you fill in the chart.*

Member Name: _____ DOB: _____ Member ID#: _____

Practitioner Name: _____

Member Prevention Screenings, Tests and Education Checklist

Prevention and Screenings			Additional Details:
<input type="checkbox"/> One physical/wellness exam (Every year)	<input type="checkbox"/> <i>Completed</i>	Date: _____	_____
<u>Women's Health</u>			
<input type="checkbox"/> Breast cancer screening (Every 2 years)	<input type="checkbox"/> <i>Completed</i>	Date: _____	_____
<input type="checkbox"/> Cervical cancer screening -Pap smear (Every 3 years or every 5 years with HPV testing)	<input type="checkbox"/> <i>Completed</i>	Date: _____	_____
<input type="checkbox"/> Chlamydia screening for <u>sexually active</u> females age 16-24 (Every year)	<input type="checkbox"/> <i>Completed</i>	Date: _____	_____
<input type="checkbox"/> Adult body mass index assessment (Every 1 - 2 years)	<input type="checkbox"/> <i>Completed</i>	Date: _____	Result: _____
<u>Cardiovascular Conditions</u>			
<input type="checkbox"/> Hypertension diagnosis - control of blood pressure <140/90 throughout the year	<input type="checkbox"/> <i>Completed</i>	Date: _____	Result: _____
<u>Diabetes Care</u>			
<input type="checkbox"/> Diabetic retinal eye exam every year (Needs to be completed by eye care professional)	<input type="checkbox"/> <i>Completed</i>	Date: _____	Result: _____
<input type="checkbox"/> Testing and control of HbA1c (<9) (Every year)	<input type="checkbox"/> <i>Completed</i>	Date: _____	Result: _____
<input type="checkbox"/> Control of blood pressure <140/90 throughout year	<input type="checkbox"/> <i>Completed</i>	Date: _____	Result: _____
<input type="checkbox"/> Medical attention for nephropathy -Kidney condition (Every year)	<input type="checkbox"/> <i>Completed</i>	Date: _____	Result: _____
<input type="checkbox"/> Avoidance of antibiotic treatment for acute bronchitis (Cough)	<input type="checkbox"/> <i>Completed</i>	Date: _____	
<input type="checkbox"/> Appropriate controller medications for asthma (oral medication, inhaler or injection dispensing events)	<input type="checkbox"/> <i>Completed</i>	Date: _____	Name of RX prescribed: _____