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