Name:_____ **Date of Birth:** _____

Please complete the following information and give to the nurse at today's visit.

Who is your primary care provider? _____

Are you diabetic? Yes No If you answered yes, when was your last A1C and what was the result? _____

If you are diabetic, when was your last eye exam and who was the physician that performed the exam? _____

For women over 40, when was your last mammogram performed? _____

For women over 21, when was your last Pap Smear performed? _____

If you are over 50, when was your last colonoscopy? _____

When was your last flu vaccine? _____

When was your last pneumonia vaccine? _____

Have you fallen in the last year? Yes No