# Preventative Medicine

Patient Name: _____ Date of Birth: _____

Date: _____

Please list the date and location of your most recent:

| | Date / Year: | Location / Physician: |
|---|---|---|
| Influenza Vaccine | | |
| Pneumonia Vaccine | | |
| Eye Exam | | |
| Mammogram | | |
| Pap Smear | | |
| Colonoscopy | | |
| Bone Density | | |

Did you have any new surgeries last year? (2017) YES NO

If yes, please list procedure and date of procedure: _____

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