ORCHARD MEDICAL CENTER WOMEN'S PREVENTIVE WELLNESS PLAN

Patient Name:_____ Date of Birth:___ _____Date:_____

Preventive Service	When was your last one?	Where?
Dental exam:		
EKG:		
Vision: **(Dilated eye exam, if diabetic)**		
Diabetic foot exam:		
Breast Cancer Screening: **(Mammogram)**		
Self-Breast Exam:		
Cervical Cancer Screening (Pap Smear):		
Osteoporosis Screening (Bone Density Measurement):		
Cholesterol Testing:		
Colorectal Cancer Screening: **Colonoscopy or Fecal Occult Blood**		
Testing for Sexually Transmitted Diseases (STD's):		
Immunizations: **Pneumococcal (Pneumonia)** **Influenza (Flu) Vaccine** **Diptheria, Tetatus and Pertussis** **Shinges (Zoster)**		
Preventative Tests:		

Patient Occupation:_____

Please describe any change in your:

Family history: _____
Weight:_____
Blood Sugar:_____
Blood Pressure:_____
Hospitalization & Other Illness:_____
Other:_____

I would like educational materials on the following (Please check all that apply):

Diet_____ Tobacco Cessation_____Weight Management____ Exercise____ Other_____

Please list the names of all your Doctors, Pharmacies & Medical Equipment Suppliers or attach a current list:

Name & Specialty	Address and phone number

Please list all your medications or attach a current list, including over-the counter medications and supplements:

Name of medicine:	Strength and how many times a day:

FUNCTIONAL ABILITY/SAFETY SCREEN:

1. Do you need help from others to perform everyday activities such as eating, getting dressed, grooming, bathing, walking or using the toilet? **___ Yes ___ No**

2. Do you need help with the phone, transportation, shopping, preparing meals, house work, laundry, medications or managing money? **___ Yes ___ No**

3. Does your home have rugs in the hallway, lack grab bars in the bathroom, lack handrails on the stairs or have poor lighting? **___ Yes ___ No**

4. Have you noticed any hearing difficulties? **___ Yes ___ No**

5. Do you feel safe at home? **___ Yes ___ No**

Do you have an advance directive or durable power of attorney? ___ Yes ___ No
(If you have one, *please bring a copy of it with you)*