Health Maintenance Flow Sheet

Patient Name:		Date:
DOB:	SS#:	SC#:
Male: Female:	Marital Status:	
Tobacco:	Alcohol:	Street Drugs:
Allergies:		

Date:	Consultations/Referrals:	Outcome:

Date:	Diagnostic Studies:	Outcome:

Preventive:	Date:	Date:	Date:	Date:	Date:	Date:	Date:	Date:
Mammogram:								
Pap Smear:								
PSA:								
Physical:								
Lipid Panel:								
Hgb A1c:								
EPSDT:								

Vitals:	Date:	Date:	Date:	Date:	Date:	Date:	Date:	Date:
B/P:								
Pulse:								
Respiration:								
Temperature:								
Weight:								
FSBS:								