LEHIGH VALLEY FAMILY PRACTICE

NAME_____ DATE OF BIRTH_____

HEALTH MAINTENANCE

ALLERGIES

_____ _____
_____ _____
_____ _____
_____ _____

PROBLEM LIST

PROBLEM	DATE	HOSPITALIZATIONS	DATE
1.		1.	
2.		2.	
3.		3.	
4.		4.	

MEDICATIONS

	BEGUN	DC'D		BEGUN	DC'd
1.			4.		
2.			5.		
3.			6.		

DATE									
AGE									
BREAST EXAM									
PAP SMEAR/ PELVIC									
RECTAL/PROSTATE									
MAMMOGRAM									
EKG									
CBC									
LIPID PANEL									
THYROID PANEL									
PSA									
STOOL FOR BLOOD									
SIGMOIDOSCOPY									
MMR									
INFLUENZA									
TETANUS									
PNEUMOVAX									