Your Personalized Prevention Plan

GREATER NEWPORT PHYSICIANS

Member Name: _____
Date of Birth: _____
PCP's Name: _____

Date of Annual Wellness Visit: _____

This is your personalized Prevention Plan. Items not checked may not apply to you.

Ht _____ Wt _____ BMI ____
(Healthy BMI: 19-24.9; Obese >30)

Blood Pressure ____ / ____
(Patient age 18-59 goal < 140/90, age 60-85 goal <150/90)

Welcome to Medicare/IPPE only
Eye Exam/Vision
Right (OD) ____ / ____
Left (OS) ____ / ____

EKG Y / N

	RECOMMENDED SCREENING TESTS AND PREVENTION			Referral Given
	Glaucoma Screening	Date:		
	Colon Cancer Screening	Name of Test: Date:		
	Mammogram	Date Completed:		
	Bone Density	Date Completed:		
	Cholesterol Test	Your Results	Reference Ranges	
		Total Chol: HDL (good): LDL (bad) Trig (fats):	Normal <200, High >240 Better if higher; Best >60 Best <100 (<70 if heart dz) Normal <155, High >200	
	Blood Sugar / Diabetes	Fasting Sugar:	Normal <100; Diabetes >126	
	Vaccines	Pneumonia :		
		Shingles :		
		Tetanus/Tdap /Td (*10years)* :		
		Flu (needed *every year* in the Fall) :		
		(other vaccines) :		
	Advanced Directive	Copy Received/Completed :		Form Given?
		Come back for your Next Visit:		

Counseling recommendations provided for (*check those that apply*)

- □ Fall prevention
- □ Physical activity
- □ Weight loss
- □ Home Safety
- □ Tobacco-use cessation
- □ Dental Evaluation
- □ Nutrition
- □ Alcohol Reduction
- □ Depression follow up