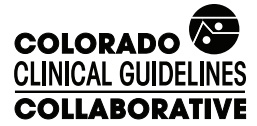


Adult Preventive Care Flowsheet



Patient Name: _____ Male: _____ Female: _____ DOB: ____/____/____ Height: _____

Date of Service								
Assess every visit. Record any change or at least annually. Document refusals. [†]								
HEALTH GUIDANCE	Diet & Physical Activity BMI of ≥30 or waist circumference >40 in. for men, >35 in. for women	Wt: ____ lbs BMI: ____ kg/m ² <input type="checkbox"/> Counseled	Wt: ____ lbs BMI: ____ kg/m ² <input type="checkbox"/> Counseled	Wt: ____ lbs BMI: ____ kg/m ² <input type="checkbox"/> Counseled	Wt: ____ lbs BMI: ____ kg/m ² <input type="checkbox"/> Counseled	Wt: ____ lbs BMI: ____ kg/m ² <input type="checkbox"/> Counseled	Wt: ____ lbs BMI: ____ kg/m ² <input type="checkbox"/> Counseled	
	Tobacco Use <input type="checkbox"/> Never <input type="checkbox"/> Former: Stop Date ____/____ <input type="checkbox"/> Current <input type="checkbox"/> Secondhand Smoke	<input type="checkbox"/> Counseled <input type="checkbox"/> Medication <input type="checkbox"/> Referral	<input type="checkbox"/> Counseled <input type="checkbox"/> Medication <input type="checkbox"/> Referral	<input type="checkbox"/> Counseled <input type="checkbox"/> Medication <input type="checkbox"/> Referral	<input type="checkbox"/> Counseled <input type="checkbox"/> Medication <input type="checkbox"/> Referral	<input type="checkbox"/> Counseled <input type="checkbox"/> Medication <input type="checkbox"/> Referral	<input type="checkbox"/> Counseled <input type="checkbox"/> Medication <input type="checkbox"/> Referral	<input type="checkbox"/> Counseled <input type="checkbox"/> Medication <input type="checkbox"/> Referral
	Alcohol Use <input type="checkbox"/> Screened for alcohol use ¹	<input type="checkbox"/> Never <input type="checkbox"/> Current: ____ drinks per ____(day/wk/mo)	<input type="checkbox"/> Never <input type="checkbox"/> Current: ____ drinks per ____(day/wk/mo)	<input type="checkbox"/> Never <input type="checkbox"/> Current: ____ drinks per ____(day/wk/mo)	<input type="checkbox"/> Never <input type="checkbox"/> Current: ____ drinks per ____(day/wk/mo)	<input type="checkbox"/> Never <input type="checkbox"/> Current: ____ drinks per ____(day/wk/mo)	<input type="checkbox"/> Never <input type="checkbox"/> Current: ____ drinks per ____(day/wk/mo)	<input type="checkbox"/> Never <input type="checkbox"/> Current: ____ drinks per ____(day/wk/mo)
	Aspirin (75-100 mg qd or 325 mg qod) Men 45-79 yrs. at increased risk for MI and women 55-79 yrs. at increased risk of ischemic stroke							
	Depression Screening ² Frequency based on risk							
	Preconception Counseling <input type="checkbox"/> Not applicable							
	Other:							

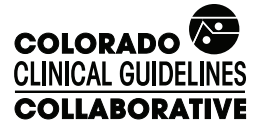
¹ Alcohol screening questions: When was the last time you had more than 3 (for women or men >65 yrs.)/4 (for men) drinks in one day? (positive screen=within the past 3 months) How many drinks do you have per week? (positive screen = >7 for women/men >65 yrs./>14 for men)
² Depression screening questions: Over the past two weeks, have you felt down, depressed, or hopeless? Over the past two weeks, have you felt little interest or pleasure in doing things? (positive screen = yes to either question)

Date of Service							
Document refusals. [†]							
IMMUNIZATIONS	Influenza q yr. if ≥ 50 yrs. or high-risk						
	Pneumococcal Once at ≥ 65 yrs. or 1 to 2 doses if high-risk						
	Tetanus/Diphtheria/Pertussis (TD/Tdap) q 10 yrs. or after 5 yrs. if exposed						
	Other Immunizations:						
	Other Immunizations:						

Date of Service								
Check small box if ordered. Record results in larger box. Document refusals. [†]								
SCREENING AND TESTS	Lipid Profile At least q 5 yrs. for women ≥45, men ≥35, and anyone at high-risk for CAD ≥20	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Colorectal Cancer Screening FOBT q 1-2 yrs., flex sig + FOBT q 5 yrs. or colonoscopy q 10 yrs. if ≥50 yrs.	<input type="checkbox"/> FOBT <input type="checkbox"/> Flex Sig + FOBT <input type="checkbox"/> Colonoscopy	<input type="checkbox"/> FOBT <input type="checkbox"/> Flex Sig + FOBT <input type="checkbox"/> Colonoscopy	<input type="checkbox"/> FOBT <input type="checkbox"/> Flex Sig + FOBT <input type="checkbox"/> Colonoscopy	<input type="checkbox"/> FOBT <input type="checkbox"/> Flex Sig + FOBT <input type="checkbox"/> Colonoscopy	<input type="checkbox"/> FOBT <input type="checkbox"/> Flex Sig + FOBT <input type="checkbox"/> Colonoscopy	<input type="checkbox"/> FOBT <input type="checkbox"/> Flex Sig + FOBT <input type="checkbox"/> Colonoscopy	<input type="checkbox"/> FOBT <input type="checkbox"/> Flex Sig + FOBT <input type="checkbox"/> Colonoscopy
	Cervical Cancer q 3 yrs. for sexually active women 21-65 yrs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Chlamydia q yr. in sexually active <25 yrs. or high-risk females	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Mammogram q 1-2 yrs. for women ≥40 yrs. up to age 70	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Bone Density women who are ≥65 yrs. or ≥60 yrs. at high risk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Hypertension Measure every 1-2 yrs. or more often if indicated	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Diabetes Screening FPG q 3 yrs. if BP sustained at >135/80	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other:								

[†]Continue to revisit refused prevention services.
 This flowsheet is not meant to be a comprehensive list of preventive services that may be indicated for a given patient. It was designed to assist clinicians in providing priority preventive services, not to replace a clinician's judgment. For references, copies of the guideline, and additional resources, go to www.coloradoguidelines.org or call 720-297-1681 or 1-866-401-2092.

Adult Preventive Care Flowsheet



Patient Name: _____ Male: _____ Female: _____ DOB: ____/____/____ Height: _____

Date of Service								
Assess every visit. Record any change or at least annually. Document refusals. [†]								
HEALTH GUIDANCE	Diet & Physical Activity BMI of ≥30 or waist circumference >40 in. for men, >35 in. for women	Wt: ____ lbs BMI: ____ kg/m ² <input type="checkbox"/> Counseled	Wt: ____ lbs BMI: ____ kg/m ² <input type="checkbox"/> Counseled	Wt: ____ lbs BMI: ____ kg/m ² <input type="checkbox"/> Counseled	Wt: ____ lbs BMI: ____ kg/m ² <input type="checkbox"/> Counseled	Wt: ____ lbs BMI: ____ kg/m ² <input type="checkbox"/> Counseled	Wt: ____ lbs BMI: ____ kg/m ² <input type="checkbox"/> Counseled	
	Tobacco Use <input type="checkbox"/> Never <input type="checkbox"/> Former: Stop Date ____/____ <input type="checkbox"/> Current <input type="checkbox"/> Secondhand Smoke	<input type="checkbox"/> Counseled <input type="checkbox"/> Medication <input type="checkbox"/> Referral	<input type="checkbox"/> Counseled <input type="checkbox"/> Medication <input type="checkbox"/> Referral	<input type="checkbox"/> Counseled <input type="checkbox"/> Medication <input type="checkbox"/> Referral	<input type="checkbox"/> Counseled <input type="checkbox"/> Medication <input type="checkbox"/> Referral	<input type="checkbox"/> Counseled <input type="checkbox"/> Medication <input type="checkbox"/> Referral	<input type="checkbox"/> Counseled <input type="checkbox"/> Medication <input type="checkbox"/> Referral	<input type="checkbox"/> Counseled <input type="checkbox"/> Medication <input type="checkbox"/> Referral
	Alcohol Use <input type="checkbox"/> Screened for alcohol use ¹	<input type="checkbox"/> Never <input type="checkbox"/> Current: ____ drinks per ____(day/wk/mo)	<input type="checkbox"/> Never <input type="checkbox"/> Current: ____ drinks per ____(day/wk/mo)	<input type="checkbox"/> Never <input type="checkbox"/> Current: ____ drinks per ____(day/wk/mo)	<input type="checkbox"/> Never <input type="checkbox"/> Current: ____ drinks per ____(day/wk/mo)	<input type="checkbox"/> Never <input type="checkbox"/> Current: ____ drinks per ____(day/wk/mo)	<input type="checkbox"/> Never <input type="checkbox"/> Current: ____ drinks per ____(day/wk/mo)	<input type="checkbox"/> Never <input type="checkbox"/> Current: ____ drinks per ____(day/wk/mo)
	Aspirin (75-100 mg qd or 325 mg qod) Men 45-79 yrs. at increased risk for MI and women 55-79 yrs. at increased risk of ischemic stroke							
	Depression Screening ² Frequency based on risk							
	Preconception Counseling <input type="checkbox"/> Not applicable							
	Other:							

¹ Alcohol screening questions: When was the last time you had more than 3 (for women or men >65 yrs.)/4 (for men) drinks in one day? (positive screen=within the past 3 months) How many drinks do you have per week? (positive screen = >7 for women/men >65 yrs./>14 for men)
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Document refusals. [†]							
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	Other Immunizations:						
	Other Immunizations:						

Date of Service								
Check small box if ordered. Record results in larger box. Document refusals. [†]								
SCREENING AND TESTS	Lipid Profile At least q 5 yrs. for women ≥45, men ≥35, and anyone at high-risk for CAD ≥20	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Colorectal Cancer Screening FOBT q 1-2 yrs., flex sig + FOBT q 5 yrs. or colonoscopy q 10 yrs. if ≥50 yrs.	<input type="checkbox"/> FOBT <input type="checkbox"/> Flex Sig + FOBT <input type="checkbox"/> Colonoscopy	<input type="checkbox"/> FOBT <input type="checkbox"/> Flex Sig + FOBT <input type="checkbox"/> Colonoscopy	<input type="checkbox"/> FOBT <input type="checkbox"/> Flex Sig + FOBT <input type="checkbox"/> Colonoscopy	<input type="checkbox"/> FOBT <input type="checkbox"/> Flex Sig + FOBT <input type="checkbox"/> Colonoscopy	<input type="checkbox"/> FOBT <input type="checkbox"/> Flex Sig + FOBT <input type="checkbox"/> Colonoscopy	<input type="checkbox"/> FOBT <input type="checkbox"/> Flex Sig + FOBT <input type="checkbox"/> Colonoscopy	<input type="checkbox"/> FOBT <input type="checkbox"/> Flex Sig + FOBT <input type="checkbox"/> Colonoscopy
	Cervical Cancer q 3 yrs. for sexually active women 21-65 yrs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Chlamydia q yr. in sexually active <25 yrs. or high-risk females	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Mammogram q 1-2 yrs. for women ≥40 yrs. up to age 70	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Bone Density women who are ≥65 yrs. or ≥60 yrs. at high risk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Hypertension Measure every 1-2 yrs. or more often if indicated	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Diabetes Screening FPG q 3 yrs. if BP sustained at >135/80	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
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