



Internal Medicine and Pediatrics of Bloomfield, PC

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HEALTH MAINTENANCE FORM

NAME: _____ DOB: _____

Please update any changes in last year or since last appointment:

New surgeries: _____

New medicines: _____

New drug allergies: _____

Do you take daily baby Aspirin 81 mg? YES NO

Are you a current smoker? YES NO

FEMALE:

Please provide the following date of service for last:

STD Screen: _____

PAP: _____

Performing Physician: _____

Mammogram: _____

Colonoscopy: _____

Performing Physician: _____

DEXA Osteoporosis Scan: _____

Cardiac Calcium Score: _____

MALE

Please provide the following date of service for last:

STD Screen: _____

PSA test/rectal exam: _____

Colonoscopy: _____

Performing Physician: _____

DEXA Osteoporosis Scan: _____

Cardiac Calcium Score: _____