

Preventive Care Checklist Form[®]

For average-risk, routine, male health assessments



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Please note:

Bold = Good evidence (from the Canadian Task Force on Preventive Health Care)
Italics = Fair evidence (from the Canadian Task Force on Preventive Health Care)
Plain text = Guidelines (from other Canadian sources)

(See reverse for references, insert for explanations)

Name: _____ Sex: _____
DOB: _____ Age: _____
Health Card: _____ Tel: _____
Address: _____

Date: _____

<p>Current Concerns</p>	<p>Lifestyle/Habits</p> <p>Diet: <i>Smoking:</i> <i>Fat/Cholesterol</i> Fiber <i>Alcohol:</i> <i>Calcium</i> Sodium Drugs:</p> <p>Exercise: <i>Sexual History:</i></p> <p>Work/Education: Family Planning/ Contraception:</p> <p>Income Below Poverty Line: <input type="checkbox"/> Yes <input type="checkbox"/> No Sleep:</p> <p>Family: Relationships:</p> <p>Update Cumulative Patient Profile</p> <p><input type="checkbox"/> Family History <input type="checkbox"/> Medications <input type="checkbox"/> Hospitalizations/Surgeries <input type="checkbox"/> Allergies</p>
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<p>Functional Inquiry</p> <table style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:50%; text-align: left;">Normal</th> <th style="width:50%; text-align: left;">Remarks</th> </tr> </thead> <tbody> <tr> <td>HEENT: <input type="checkbox"/></td> <td></td> </tr> <tr> <td>CVS: <input type="checkbox"/></td> <td></td> </tr> <tr> <td>Resp: <input type="checkbox"/></td> <td></td> </tr> <tr> <td>GI: <input type="checkbox"/></td> <td></td> </tr> <tr> <td>GU: <input type="checkbox"/></td> <td></td> </tr> <tr> <td>Sexual Function: <input type="checkbox"/></td> <td></td> </tr> </tbody> </table>	Normal	Remarks	HEENT: <input type="checkbox"/>		CVS: <input type="checkbox"/>		Resp: <input type="checkbox"/>		GI: <input type="checkbox"/>		GU: <input type="checkbox"/>		Sexual Function: <input type="checkbox"/>		<table style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:50%; text-align: left;">Normal</th> <th style="width:50%; text-align: left;">Remarks</th> </tr> </thead> <tbody> <tr> <td>MSK: <input type="checkbox"/></td> <td></td> </tr> <tr> <td>Neuro: <input type="checkbox"/></td> <td></td> </tr> <tr> <td>Derm: <input type="checkbox"/></td> <td></td> </tr> <tr> <td>Mental Health: <input type="checkbox"/></td> <td><i>Depression screen</i> <input type="checkbox"/> positive <input type="checkbox"/> negative</td> </tr> <tr> <td>Constitutional SX: <input type="checkbox"/></td> <td></td> </tr> </tbody> </table>	Normal	Remarks	MSK: <input type="checkbox"/>		Neuro: <input type="checkbox"/>		Derm: <input type="checkbox"/>		Mental Health: <input type="checkbox"/>	<i>Depression screen</i> <input type="checkbox"/> positive <input type="checkbox"/> negative	Constitutional SX: <input type="checkbox"/>	
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<p style="writing-mode: vertical-rl; transform: rotate(180deg); font-size: small;">Education/ Counseling</p> <p>Behavioural</p> <p><input type="checkbox"/> <i>adverse nutritional habits</i> <input type="checkbox"/> <i>dietary advice on fat/cholesterol (30-69 yrs)</i> <input type="checkbox"/> adequate calcium intake (1000 to 1500mg/d) <input type="checkbox"/> adequate vitamin D (400 to 1000 IU /day) <input type="checkbox"/> <i>regular, moderate physical activity</i> <input type="checkbox"/> <i>avoid sun exposure, use protective clothing</i> <input type="checkbox"/> <i>safe sex practices/STD counseling</i></p> <p>Obesity (BMI ≥30) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> weight loss counselling if overweight <input type="checkbox"/> screen for mental illness <input type="checkbox"/> multidisciplinary approach</p> <p>Smoking <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> smoking cessation <input type="checkbox"/> nicotine replacement therapy/other drugs <input type="checkbox"/> <i>dietary advice on fruits and green leafy vegetables</i> <input type="checkbox"/> <i>referral to validated smoking cessation program</i></p>	<p>Alcohol <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> <i>case finding for problem drinking</i> <input type="checkbox"/> <i>counseling for problem drinking</i></p> <p>Elderly <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> cognitive assessment (if concerns) <input type="checkbox"/> fall assessment (if history of falls)</p> <p>Oral Hygiene</p> <p><input type="checkbox"/> brushing/flossing teeth <input type="checkbox"/> fluoride (toothpaste/supplement) <input type="checkbox"/> <i>tooth scaling and prophylaxis</i> <input type="checkbox"/> smoking cessation</p>	<p>Personal Safety</p> <p><input type="checkbox"/> hearing protection <input type="checkbox"/> noise control programs <input type="checkbox"/> seat belts</p> <p>Parents with children <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> <i>poison control prevention</i> <input type="checkbox"/> <i>smoke detectors</i> <input type="checkbox"/> <i>non-flammable sleepwear</i> <input type="checkbox"/> <i>hot water thermostat settings (<54°C)</i></p>
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Disclaimer: This form is a guide to the adult periodic health examination. Last updated December 2010. The recommendations are for average-risk adults.

Endorsed by:
 The College of Family Physicians of Canada
 Le Collège des médecins de famille du Canada

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Name: _____

Physical Examination

HR: _____ BP: _____ RR: _____ HT: _____ WT: _____ BMI: _____
 Waist Circumference: _____ Ratio: _____
 Hip Circumference: _____

Eyes: _____ Snellen sight card: R _____
 L _____ Abdo: _____

Nose: _____ Ano-Rectum: _____

Ears: _____ whispered voice test: R _____
 L _____ Genitalia: _____

Mouth/Throat: _____ Neuro: _____

Neck/Thyroid: _____ Derm: _____

CVS: _____ MSK/Joints: _____

Resp: _____ Extremities: _____

Age	21-64 years	≥ 65 years
Labs/Investigations	<input type="checkbox"/> Hemoccult multiphase q1-2 years (age ≥50) OR <input type="checkbox"/> <i>Sigmoidoscopy</i> OR <input type="checkbox"/> Colonoscopy <input type="checkbox"/> Gonorrhea/Chlamydia/Syphilis/HIV/HSV screen (high risk) <input type="checkbox"/> Fasting Lipid Profile (≥40 yr or sooner if at risk) <input type="checkbox"/> <i>Fasting Blood Glucose, at least q3 yrs (≥40 yr or sooner if at risk)</i> <input type="checkbox"/> Bone Mineral Density if at risk (reassess risk in 1-3 yr if moderate risk, in 5 yr if low risk)	<input type="checkbox"/> Hemoccult Multiphase q1-2 years OR <input type="checkbox"/> <i>Sigmoidoscopy</i> OR <input type="checkbox"/> Colonoscopy <input type="checkbox"/> <i>Audioscope (or inquire/whispered voice test)</i> <input type="checkbox"/> Fasting Lipid Profile <input type="checkbox"/> <i>Fasting Blood Glucose, at least q3 yrs (more often if at risk)</i> <input type="checkbox"/> Bone Mineral Density (reassess risk in 1-3 yr if moderate risk, in 5 yr if low risk)
Immunizations	<input type="checkbox"/> Tetanus vaccine q10yr <input type="checkbox"/> Meningococcal vaccine (high risk) <input type="checkbox"/> Influenza vaccine q1yr <input type="checkbox"/> Herpes zoster vaccine (age ≥60) <input type="checkbox"/> Pneumococcal vaccine (high risk) <input type="checkbox"/> Acellular pertussis vaccine <input type="checkbox"/> <i>Varicella vaccine (2 doses)</i> <input type="checkbox"/> <i>Varicella Immunity</i>	<input type="checkbox"/> Tetanus vaccine q10yr <input type="checkbox"/> Influenza vaccine q1yr <input type="checkbox"/> Herpes zoster vaccine <input type="checkbox"/> Pneumococcal vaccine <input type="checkbox"/> Acellular pertussis vaccine <input type="checkbox"/> <i>Varicella vaccine (2 doses)</i> <input type="checkbox"/> <i>Varicella Immunity</i>

Assessment and Plans:

Date: _____

Signature: _____

References: See explanation sheet for references and recommendations.

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