



PRIMARY CARE
with MUSC Health

HEALTH MAINTENANCE UPDATE FORM

PLEASE COMPLETE PRIOR TO SEEING
YOUR MEDICAL ASSISTANT OR NURSE.

TODAY'S DATE: _____

PATIENT NAME: _____

DATE OF BIRTH: _____

PREVENTATIVE HEALTHCARE SCREENINGS

Hepatitis C: DATE _____

HIV: DATE _____

COLORECTAL SCREEN (AGE 50-75)

COLONOSCOPY: DATE _____ ___ NORMAL OR ___ ABNORMAL

COLOGARD: DATE _____ ___ NORMAL OR ___ ABNORMAL

EYE EXAM (DIABETIC PATIENTS ONLY)

COMPLETED AT: ___ JERVEY EYE ___ SOUTHERN EYE ___ OTHER: _____

CERVICAL SCREEN (FEMALE PATIENTS ONLY)

PAP SMEAR: DATE _____ ___ NORMAL OR ___ ABNORMAL

Hysterectomy: DATE _____

BREAST SCREEN (FEMALE PATIENTS ONLY)

MAMMOGRAPHY (AGE 40-74) : DATE _____

___ NORMAL OR ___ ABNORMAL

COMPLETED AT ___ ST FRANCIS ___ PRISMA ___ INNERVISION ___ OTHER: _____

DAILY MAINTENANCE

DO YOU TAKE A DAILY ASPIRIN? ___ YES ___ NO

DO YOU USE HEARING AIDS? ___ YES ___ NO

DO YOU WEAR GLASSES? ___ YES ___ NO

DO YOU HAVE ANY LANGUAGE OR COMMUNICATION BARRIERS? YES OR NO _____

SOCIAL INTERACTION

HOW OFTEN DO YOU SPEND TIME WITH OTHERS?

___ NONE, I PREFER ISOLATION ___ OCCASIONAL ___ FREQUENT

DOES A PARTNER, OR ANYONE AT HOME, HURT, HIT, OR THREATEN YOU? ___ YES ___ NO

ARE YOU SEXUALLY ACTIVE? ___ YES ___ NO

IN A RELATIONSHIP WITH A MALE PARTNER: ___

IN A RELATIONSHIP WITH A FEMALE PARTNER: ___

MARITAL STATUS: _____ OCCUPATION: _____

IMMUNIZATIONS

FLU VACCINE: DATE _____ PREVVAR 13 or 20: DATE _____ TDAP: DATE _____

PNEUMOVAX: DATE _____ HEPATITIS B: DATE _____ SHINGRIX: DATE _____

COVID VACCINE: DATE _____ MANUFACTURER _____