

adult's personal screening and exam schedule

Name _____ Date of Birth _____

After reviewing with your doctor, circle or highlight the corresponding box to indicate the age when specific tests are needed. Record in pen the date the test was completed.

TEST/EXAM	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99		
Physical Exam																																					
Total Skin Exam																																					
Rectal Exam																																					
Stool Card for Blood																																					
Breast Exam																																					
Pelvic Exam																																					
Pap Test																																					
HPV with Pap																																					
Prostate Exam																																					
PSA Test																																					
Cholesterol/ Blood Lipids																																					
Mammogram																																					
Bone Density Test																																					
Sigmoidoscope/ Colonoscope																																					
Vision Exam																																					
<i>Other Test</i>																																					

Other tests to discuss with your doctor: EKG, stress test, urinalysis, thyroid tests, etc.