The Kennedy Clinic PLLC

Name: ______________________________ DOB: ____/____/______

My Exams and Tests

Exam or Test	Date	Result
Yearly Physical	____________	___ Normal ___ Not Normal ___Not Sure
Eye Exam	____________	___ Normal ___ Not Normal ___Not Sure
Hearing Test	____________	___ Normal ___ Not Normal ___Not Sure
Dental Visit	____________	___ Normal ___ Not Normal ___Not Sure
Cholesterol Check	____________	___ Normal ___ Not Normal ___Not Sure
Blood Sugar Check	____________	___ Normal ___ Not Normal ___Not Sure
Colonoscopy or Stool Test	____________	___ Normal ___ Not Normal ___Not Sure
Hepatitis C Screening (Blood)	____________	___ Normal ___ Not Normal ___Not Sure
Prostate Exam	____________	___ Normal ___ Not Normal ___Not Sure
Pap Smear	____________	___ Normal ___ Not Normal ___Not Sure
Mammogram	____________	___ Normal ___ Not Normal ___Not Sure
DEXA Scan (Bone Density)	____________	___ Normal ___ Not Normal ___Not Sure
Other:____________	____________	___ Normal ___ Not Normal ___Not Sure
Other:____________	____________	___ Normal ___ Not Normal ___Not Sure
Other:____________	____________	___ Normal ___ Not Normal ___Not Sure