TRACKING MY PROGRESS

Please Keep this form in a visible place for you to remember.

ALL APPROPRIATE TESTING MUST BE COMPLETED PRIOR TO RECEIVING AN EVALUATION APPOINTMENT. PLEASE FAX THIS FORM TO 702-383-3035 WHEN COMPLTED.

Patient Name: ___________________________________ D.O.B: ____________

- **Colonoscopy**
  - Date of Exam: _________
  - Physician Name: ______________________
  - Phone: ___________________ Fax: ____________________

- **Mammogram**
  - Date of Exam: _________
  - Physician Name: ______________________
  - Phone: ___________________ Fax: ____________________

- **PAP Smear**
  - Date of Exam: _________
  - Physician Name: ______________________
  - Phone: ___________________ Fax: ____________________

- **Dental Exam**
  - Date of Exam: _________
  - Physician Name: ______________________
  - Phone: ___________________ Fax: ____________________

- **Immunization Records**
  - Hepatitis A x 2 doses: Dose Date #1 : ___________ Date Dose #2 : ___________
  - Tetanus (TDAP): Date ___________
  - Pneumonia: Date ___________
  - Hepatitis B x 4 doses: Dose #1 : ________Dose #2 : ________ Dose #3 : ________ Dose #4________
  - Flu Shot: Date ____________