



◆ = MANDATORY / BASELINE FIELDS

◆ PATIENT NAME		◆ HEALTH # (E.G. BC PHN)		◆ DATE OF VISIT (DD-MMM-YYYY)	
◆ BIRTHDATE (DD-MMM-YYYY)	◆ GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	◆ PHONE (INCLUDE AREA CODE)		CHART NUMBER	
PRACTICE TEAM ID			◆ PROVIDER ID (MSP PRACTITIONER NUMBER / NAME)		
CO-MORBID CONDITIONS					
<input type="checkbox"/> ALCOHOL OVERUSE	<input type="checkbox"/> CARDIOMYOPATHY	<input type="checkbox"/> DEPRESSION	<input type="checkbox"/> LIPID ABNORMALITY	<input type="checkbox"/> PVD	<input type="checkbox"/> VALVULAR HD
<input type="checkbox"/> ARTHRITIS	<input type="checkbox"/> CHF	<input type="checkbox"/> DIABETES	<input type="checkbox"/> LIVER DISEASE	<input type="checkbox"/> SMOKING	
<input type="checkbox"/> ASTHMA	<input type="checkbox"/> COPD	<input type="checkbox"/> HYPERTENSION	<input type="checkbox"/> OBESITY	<input type="checkbox"/> STROKE - CVD	
<input type="checkbox"/> ATRIAL FIBRILLATION	<input type="checkbox"/> CAD	<input type="checkbox"/> KIDNEY DISEASE	<input type="checkbox"/> OTHER RHYTHM PROBLEM	<input type="checkbox"/> SUBSTANCE ABUSE	

PATIENT DATA, BY DATE

✓ = RECALL

REVIEW		MOST RECENT DATA		NEW DATA
Hypertension	Blood Pressure If applicable, check Hypertension co-morbidity			ENTER VALUE /
Overweight	BMI Measurement: 25-30 = Overweight; > 30 = Obese If applicable, check Obesity co-morbidity			<input type="checkbox"/> LBS <input type="checkbox"/> FT IN <input type="checkbox"/> KG - or - <input type="checkbox"/> CM BMI:
Healthy Eating	Advise on Nutritional Habits (increase fibre, decrease fat)			<input type="checkbox"/> ADVICE <input type="checkbox"/> INAPPROPRIATE
Physical Activity Status	Patient completing moderate physical activity (30+ minutes most days a week) If not, advise on physical activity			PATIENT PHYSICALLY ACTIVE <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> ADVICE
Tobacco Use	Smoking status			<input type="checkbox"/> NON-SMOKER <input type="checkbox"/> PREVIOUS > 5 YRS. <input type="checkbox"/> PREVIOUS < 5 YRS. <input type="checkbox"/> CURRENT
	Smoking Cessation			<input type="checkbox"/> ADVICE <input type="checkbox"/> COUNSELING
Alcohol Use	Assessed with CAGE, MAST, AUDIT or Clinical Judgment			PROBLEM DRINKER <input type="checkbox"/> YES <input type="checkbox"/> NO
	Counseling			<input type="checkbox"/> COUNSELED
Colon Screening	Haemoccult Test			<input type="checkbox"/> ORDERED (DATE DD-MMM-YYYY) <input type="checkbox"/> COMPLETED <input type="checkbox"/> INAPPROPRIATE
Influenza	Vaccination			<input type="checkbox"/> COMPLETED (DATE DD-MMM-YYYY) <input type="checkbox"/> INAPPROP/REFUSED
Baseline	Patient is part of Prevention baseline			<input type="checkbox"/> YES

WOMEN

Cervical Screening	Papanicolaou Smear			<input type="checkbox"/> COMPLETED (DATE DD-MMM-YYYY) <input type="checkbox"/> INAPPROPRIATE
	Recall Status			<input type="checkbox"/> 6 mo <input type="checkbox"/> 1 yr <input type="checkbox"/> 2 yr
Breast Screening	Mammography			<input type="checkbox"/> COMPLETED (DATE DD-MMM-YYYY) <input type="checkbox"/> INAPPROPRIATE
	Clinical Breast Exam			<input type="checkbox"/> COMPLETED

COMMENTS

NOTE: These are selected recommended maneuvers from the Canadian Task Force on Preventive Health Care guidelines.