ThermTech

US HealthCenter
PERSONAL • PREDICTIVE • HEALTH

2024-2025 Preventive Screening Form

Use this form to verify that you are up-to-date on your appropriate age and gender preventive screenings. Review the criteria below and initial and sign at the bottom to indicate that you are complete.

Name of Patient:_____**Date of Birth:** ____/_____/_____

The age and gender specific screenings listed below are based on the U.S. Preventive Services Task Force recommendations. Please talk to your doctor about what is right for you. Below are some suggested screenings to discuss with you doctor.

Women 21 and older:

- ☐ Cervical Cancer Screening
- ☐ Breast screening (ask to your doctor to see if you should have a mammogram)

Women Over 40:

- ☐ Mammogram (Ask your doctor if this is recommended for you).

Women over 50: Ask your doctor about what is right for you.

Colorectal Cancer Screening:

- ☐ Colonoscopy (Often recommended every 10 years)
- ☐ Sigmoidoscopy (Often recommended every 5 years)
- ☐ Fecal Occult Blood Test (Often recommended yearly)

Men over 50: Ask your doctor about what is right for you.

Colorectal Cancer Screening:

- ☐ Colonoscopy (Often recommended every 10 years)
- ☐ Sigmoidoscopy (Often recommended every 5 years)
- ☐ Fecal Occult Blood Test (Often recommended yearly)

Prostate Screening:

- ☐ Prostate Exam

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To be completed by participant:

I certify that I, the person patient named above, have completed the following initialed items.

Please initial completed item and sign below:

_____I am current on all my preventive screenings (see criteria above).

Participant Signature: _____ Date: _____/_____/_____

Return completed form to Allison Knight, Health Coach by September 15th, 2025

Confidential Fax: 877.419.3374

Questions can be directed to Allison Knight

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