MEN'S PERSONAL PREVENTIVE PLAN for _____ Date:_____

Preventive Service	Most Recent Date / Result (if indicated)	Date Next Due or Not Indicated (N/I)
Blood Pressure (BP) check	Date _____ BP ____/_____ □ Normal □ High □ Low	Next Due _____ □ N/I
Height/Weight and Body Mass Index (BMI)	Date _____ Ht _____ Wt _____ BMI _____ □ Underweight □ Normal □ Overweight □ Obese	Next Due _____ □ N/I
Colon cancer test	Date _____ Test _____ Result_____	Next Due _____ □ N/I
Lung cancer test	Date _____ Result _____	Next Due _____ □ N/I
Prostate cancer test	Date _____	Next Due _____ □ N/I
Blood sugar (diabetes check)	Date _____ Result ____ □ Normal □ Pre-diabetes □ Diabetes	Next Due _____ □ N/I
Bone density test (DEXA)	Date _____ □ Normal □ Osteopenia □ Osteoporosis	Next Due _____ □ N/I
Cholesterol test	Date _____ Total ____ LDL ____ HDL ____	Next Due _____ □ N/I
Hepatitis C Virus test	Date _____	Next Due _____ □ N/I
Sexually Transmitted Infection tests	Date _____	Next Due _____ □ N/I
Vision/Glaucoma test	Date _____	Next Due _____ □ N/I
Influenza (flu) vaccine	Date _____	Next Due _____ □ N/I
Pneumonia vaccine	Polysaccharide Vaccine (PPSV23) Date _____ Conjugate Vaccine (PCV13) Date _____	Next Due _____ □ N/I
Tetanus vaccine (recommended but may not covered by Part B)	Tetanus /diphtheria (Td) Date _____ Tetanus/ diphtheria/ pertussis (Tdap) Date _____	Next Due _____ □ N/I
Shingles vaccine (recommended but not covered by Part B)	Date _____	Next Due _____ □ N/I

Things that may be affecting my health	Information to review	Referral/action
□ Poor diet	□ Healthy Eating brochure □ My Plate for Older Adults	□ See a dietician □↑fruits and vegetables □ ↑whole grains/fiber □↓ salt intake □↓saturated fats
□ Obesity	□	□ Lose ____ pounds
□ Alcohol consumption	□ Alcohol Use in Older Adults brochure	□ Reduce alcohol intake to _____
□ Smoking	□ Tobacco Cessation Services	□ Sign up for "Quit Smoking" class
□ Not enough exercise	□ Physical Activity brochure □ Exercise videos https://go4life.nia.nih.gov/ □ Work Out to Go exercises	□ ↑ activity to ____ min ___ times/week □ Do strengthening/balance/flexibility exercises 2x/week □ Sign up for exercise class at senior center
□ Not enough sleep	□ Sleep Health	□ Try to sleep at least 7 hours/night
□ Not taking medicine(s) correctly	□ Medicine brochure	□ Follow medicine instructions
□ Problem with balance/ walking or history of falls	□ Strong and Stable Brochure □ Balance Basics Brochure □ Falls brochure	□ Do "Strong and Stable" exercises twice a week □ Do "Balance Basics" exercises twice a week □ Physical therapy evaluation
□ Risky sexual activity	□ Sexuality brochure	□ Use condoms □ Have fewer partners
□ Problem hearing	□ Hearing Loss brochure	□ Hearing test (audiometry)
□ Problem seeing	□ Aging and Your Eyes brochure	□ See the eye doctor
□ Problems with memory	□ Forgetfulness brochure	□ Further memory tests □ Alzheimer's Orange County
□ Problems with teeth/mouth	□ Taking Care of Your Teeth and Mouth brochure	□ See the dentist □ Floss daily
□ Depression/Anxiety/stress	□ Depression brochure	
□ Safety risks in home		
□ Other _____		
□ Other _____		
□ Other _____		

Action Plan: The first thing I will work on will be (choose **one** goal) _____, and I will do (choose **one** action) _____. Signed: _____ Date: _____