

**WOMEN'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		Next Due _____ <input type="checkbox"/> N/I
Height/Weight and Body Mass Index (BMI)	Date _____ Ht _____ Wt _____ BMI _____ <input type="checkbox"/> Underweight <input type="checkbox"/> Normal <input type="checkbox"/> Overweight <input type="checkbox"/> Obese	Next Due _____ <input type="checkbox"/> N/I
Colon cancer screening	Date _____ Test _____ Result _____	Next Due _____ <input type="checkbox"/> N/I
Lung cancer screening	Date _____ Result _____	Next Due _____ <input type="checkbox"/> N/I
Mammogram	Date _____ Result _____	Next Due _____ <input type="checkbox"/> N/I
Pap Smear	Date _____ Result _____	Next Due _____ <input type="checkbox"/> N/I
Blood sugar (diabetes check)	Date _____ Result _____ <input type="checkbox"/> Normal <input type="checkbox"/> Pre-diabetes <input type="checkbox"/> Diabetes	Next Due _____ <input type="checkbox"/> N/I
Bone density test (DEXA)	Date _____ <input type="checkbox"/> Normal <input type="checkbox"/> Osteopenia <input type="checkbox"/> Osteoporosis	Next Due _____ <input type="checkbox"/> N/I
Cholesterol test	Date _____ Total _____ LDL _____ HDL _____	Next Due _____ <input type="checkbox"/> N/I
Hepatitis C Virus test	Date _____	Next Due _____ <input type="checkbox"/> N/I
Sexually Transmitted Infection tests	Date _____	Next Due _____ <input type="checkbox"/> N/I
Vision/Glaucoma test	Date _____	Next Due _____ <input type="checkbox"/> N/I
Influenza (flu) vaccine	Date _____	Next Due _____ <input type="checkbox"/> N/I
Pneumonia vaccine	Polysaccharide Vaccine (PPSV23) Date _____ Conjugate Vaccine (PCV13) Date _____	Next Due _____ <input type="checkbox"/> N/I
Tetanus vaccine (recommended but not covered by Part B)	Tetanus /diphtheria (Td) Date _____ Tetanus/ diphtheria/ pertussis (Tdap) Date _____	Next Due _____ <input type="checkbox"/> N/I
Shingles vaccine (recommended but not covered by Part B)	Date _____	Next Due _____ <input type="checkbox"/> N/I

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

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