

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 ____/____ <input type="checkbox"/> Normal <input type="checkbox"/> High <input type="checkbox"/> Low	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 test	Date _____ Test _____ Result _____	Next Due _____ <input type="checkbox"/> N/I
Lung cancer test	Date _____ Result _____	Next Due _____ <input type="checkbox"/> N/I
Prostate cancer test	Date _____	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
HIV/STD 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 may 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
COVID-19 vaccine	Type: _____ Dates: _____ _____ _____	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"/> See above	<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"/> Brochures (Physical Activity, Workout to Go, Strong and Steady) <input type="checkbox"/> https://www.nia.nih.gov/health/exercise-physical-activity	<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 and Older Adults brochure	<input type="checkbox"/> Try to sleep at least 7 hours/night
<input type="checkbox"/> Not taking medicine(s) correctly	<input type="checkbox"/> Safe Use of 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"/> 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 in Later Life brochure	<input type="checkbox"/> Use condoms <input type="checkbox"/> Have fewer partners
<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	https://www.ncoa.org/article/18-steps-to-fall-proofing-your-home	<input type="checkbox"/> items to address:
<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: _____