WOMEN'S PREVENTIVE WELLNESS PLAN

Patient Name_____ Date_____

Preventive Service	Frequency	Last Done
Body Mass Index (BMI)____ Height _____ Weight _____	**Annually**	
Blood Pressure _____/_____	• **Every 2 yrs, if BP </= 120/80 mm hg;** • **Annually, if BP >120-139/80-89 mm hg**	
Vision	• **Every 3 yrs up to age 40;** • **Every 2 yrs aged 40+**	
Breast Cancer Screening (Mammogram)	• **Every 2 yrs, aged 50-74 yrs**	
Cervical Cancer Screening (Pap Smear)	• **Every 3 yrs, aged 21-64 yrs;** • **Every 5 yrs, aged 30-65 with HPV testing**	
Osteoporosis Screening (Bone Density Measurement)	• **Routinely, for women aged 65+** • **Routinely, for women aged 60-64 with risk factors**	
Cholesterol Testing	**Regularly beginning at age 20 with risk factors**	
Diabetes Screening	**With a sustained BP >/= 135/80 mm Hg**	
Colorectal Cancer Screening	• **Annually, Fecal Occult Blood Stool (FOBS);** • **Every 5 yrs, Sigmoidoscopy with FOBS;** • **Every 10 yrs, Colonoscopy**	
Sexually Transmitted Diseases (STD's)	**As necessary for those with risk factors**	
Depression Screening	**As necessary for those with risk factors**	
Alcohol Misuse Screening	**As necessary for those with risk factors**	
Immunizations: **Pneumococcal (Pneumonia) Vaccine** **Influenza (Flu) Vaccine**	• **Pneumonia: 1-2 doses up to age 64;** • **Pneumonia: 1 dose age 65+** • **Influenza: Annually**	
Other		

Your major risk factors:

Family history of _____ Obesity_____ Diabetes_____
Hypertension_____ Fall Risk_____ Smoking Use_____ Other_____

Recommendations for improvement:

Diet_____ Tobacco Cessation_____Weight Management____ Exercise____ Other_____

Referrals

For Staff Use: *[list handouts, referrals, or other followup instructions here]*