

MEN'S PERSONAL PREVENTIVE PLAN for _____ Date: _____

Preventive Service	Most Recent Date / Result (if indicated)	Date Next Due or Not Indicated (NI)
Blood Pressure (BP)	Date _____ BP _____	Next Due _____ <input type="checkbox"/> NI
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"/> NI
Vision / Glaucoma	Date _____	Next Due _____ <input type="checkbox"/> NI
Prostate Specific Antigen (PSA)	Date _____	Next Due _____ <input type="checkbox"/> NI
Bone Density (DEXA)	Date _____ <input type="checkbox"/> Normal <input type="checkbox"/> Osteopenia <input type="checkbox"/> Osteoporosis	Next Due _____ <input type="checkbox"/> NI
Cholesterol test	Date _____ Total _____ LDL _____ HDL _____	Next Due _____ <input type="checkbox"/> NI
Blood glucose/HbA1c	Date _____ <input type="checkbox"/> Normal <input type="checkbox"/> Pre-diabetes <input type="checkbox"/> Diabetes	Next Due _____ <input type="checkbox"/> NI
Colon cancer	Date _____ Procedure _____	Next Due _____ <input type="checkbox"/> NI
Sexually Transmitted Infections	Date _____	Next Due _____ <input type="checkbox"/> NI
Hepatitis C Virus	Date _____	Next Due _____ <input type="checkbox"/> NI
Influenza vaccine	Date _____	Next Due _____ <input type="checkbox"/> NI
Pneumonia vaccine	Date _____	Next Due _____ <input type="checkbox"/> NI
Tetanus vaccine (recommended but not covered by Part B)	Date _____ Tetanus /diphtheria _____ Tetanus/ diphtheria/ pertussis __	Next Due _____ <input type="checkbox"/> NI
Shingles vaccine (recommended but not covered by Part B)	Date _____	Next Due _____ <input type="checkbox"/> NI

Behavior Rx

- Dietary change: _____ Lose Weight: _____ lbs Gain Weight _____ lbs
- Exercise: _____ Quit Smoking Reduce Alcohol
- Other: _____

Referrals made/provided:

- Dental _____
 PT evaluation _____
 Optometry _____
- Psychiatry/counseling _____
 Dietician/nutrition counseling _____
- Dementia Evaluation _____
 Other _____

Informational Brochures	Educational Materials	Other
<input type="checkbox"/> Abuse Red Flags <input type="checkbox"/> Adult Day Care Fact Sheet <input type="checkbox"/> Adult Protective Services (APS) <input type="checkbox"/> Age Well <input type="checkbox"/> Alzheimer's Association Orange County Chapter <input type="checkbox"/> Caregiver Resource Center <input type="checkbox"/> Council on Aging <input type="checkbox"/> Financial Exploitation <input type="checkbox"/> Friendly Visitor Program <input type="checkbox"/> Health Insurance Counseling & Advocacy Program (HICAP) <input type="checkbox"/> Healthier Living <input type="checkbox"/> Information, Assistance and Resources Phone List <input type="checkbox"/> Long Term Care Ombudsman <input type="checkbox"/> OC Links <input type="checkbox"/> Office on Aging Infoline <input type="checkbox"/> Protect Yourself From Abuse, Neglect and Exploitation <input type="checkbox"/> Protect Against Scams <input type="checkbox"/> Senior/Community Center List <input type="checkbox"/> Senior Health Outreach Prevention Program (SHOPP) <input type="checkbox"/> SeniorServ <input type="checkbox"/> Tobacco Cessation Services <input type="checkbox"/> Veteran's Service Office	<input type="checkbox"/> Alcohol Use in Older Adults <input type="checkbox"/> Balance Basics Brochure <input type="checkbox"/> Depression Age Page <input type="checkbox"/> Dietary Supplements Age Page <input type="checkbox"/> Driving Age Page <input type="checkbox"/> Forgetfulness Age Page <input type="checkbox"/> Healthy Eating Age Page <input type="checkbox"/> Medicine Age Page <input type="checkbox"/> NIA Exercise and Physical Activity <input type="checkbox"/> Pain Age Page <input type="checkbox"/> Physical Activity Age Page <input type="checkbox"/> Prescription Medication Disposal flyer <input type="checkbox"/> Sexuality Age Page <input type="checkbox"/> Sleep Health <input type="checkbox"/> Strong And Stable Brochure <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____	<input type="checkbox"/> Advanced Health Care Directive Form <input type="checkbox"/> How to Register Your Advance Directive <input type="checkbox"/> Registration Form for Advance Directive <input type="checkbox"/> Things my loved ones need to know <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____