

CREATING
HEALTH



CONNECTING WISCONSIN WOMEN

h·e·a·l·t·h
planner

part of a women's health project of
WISCONSIN PUBLIC TELEVISION

in partnership with

University of Wisconsin-Extension Cooperative Extension



Health Care Providers

Use this section to record contact information for your health care providers

Primary Care Provider

NAME _____

SERVICE/SPECIALTY _____

STAFF CONTACT _____

PHONE NUMBER (OFFICE HOURS) _____ AFTER HOURS/EMERGENCY PHONE NUMBER _____

LOCATION _____

OB/GYN

NAME _____

SERVICE/SPECIALTY _____

STAFF CONTACT _____

PHONE NUMBER (OFFICE HOURS) _____ AFTER HOURS/EMERGENCY PHONE NUMBER _____

LOCATION _____

Eye Doctor

NAME _____

SERVICE/SPECIALTY _____

STAFF CONTACT _____

PHONE NUMBER (OFFICE HOURS) _____ AFTER HOURS/EMERGENCY PHONE NUMBER _____

LOCATION _____



Dentist

NAME _____

SERVICE/SPECIALTY _____

STAFF CONTACT _____

PHONE NUMBER (OFFICE HOURS) _____ AFTER HOURS/EMERGENCY PHONE NUMBER _____

LOCATION _____

Pharmacist

NAME _____

SERVICE/SPECIALTY _____

STAFF CONTACT _____

PHONE NUMBER (OFFICE HOURS) _____ AFTER HOURS/EMERGENCY PHONE NUMBER _____

LOCATION _____

Mental Health Provider

NAME _____

SERVICE/SPECIALTY _____

STAFF CONTACT _____

PHONE NUMBER (OFFICE HOURS) _____ AFTER HOURS/EMERGENCY PHONE NUMBER _____

LOCATION _____

Other Specialist

NAME _____

SERVICE/SPECIALTY _____

STAFF CONTACT _____

PHONE NUMBER (OFFICE HOURS) _____ AFTER HOURS/EMERGENCY PHONE NUMBER _____

LOCATION _____



Health Care Advocates



NAME

PHONE NUMBERS

NAME

PHONE NUMBERS

NAME

PHONE NUMBERS

Other Specialists

NAME

SERVICE/SPECIALTY

STAFF CONTACT

PHONE NUMBER (OFFICE HOURS)

AFTER HOURS/EMERGENCY PHONE NUMBER

LOCATION

NAME

SERVICE/SPECIALTY

STAFF CONTACT

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PHONE NUMBERS

Other Specialists

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AFTER HOURS/EMERGENCY PHONE NUMBER

LOCATION

NAME

SERVICE/SPECIALTY

STAFF CONTACT

PHONE NUMBER (OFFICE HOURS)

AFTER HOURS/EMERGENCY PHONE NUMBER

LOCATION



notes



notes



Menstrual Cycle

January	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	

notes

February	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
	17	18	19	20	21	22	23	24	25	26	27	28	29			

notes

March	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	

notes

April	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
	17	18	19	20	21	22	23	24	25	26	27	28	29	30		

notes

May	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	

notes

June	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
	17	18	19	20	21	22	23	24	25	26	27	28	29	30		

notes

Menstrual Cycle

July	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	

notes

August	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	

notes

September	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
	17	18	19	20	21	22	23	24	25	26	27	28	29	30		

notes

October	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	

notes

Novemeber	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	

notes

December	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	

notes

Screening

Have you ever had an abnormal Pap Smear? _____ Yes _____ No

When _____ Treatment: _____

Past and current history with sexually transmitted disease: _____

PAP SMEAR & PELVIC EXAMS

DATE	RESULTS	DATE	RESULTS

MONTHLY BREAST CHECK

DATE	RESULTS	DATE	RESULTS

MAMMOGRAMS AND CLINICAL BREAST EXAM

DATE	RESULTS	DATE	RESULTS

Screening

Have you ever had an abnormal Pap Smear? _____ Yes _____ No

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DATE	RESULTS	DATE	RESULTS

MONTHLY BREAST CHECK

DATE	RESULTS	DATE	RESULTS

MAMMOGRAMS AND CLINICAL BREAST EXAM

DATE	RESULTS	DATE	RESULTS

Make notes here of any prescription or over-the-counter medications, along with herbal supplements and vitamins, etc. You may want to separate your prescriptions from your supplements.

MEDICATIONS/SUPPLEMENTS		
NAME	USE DATES	HOW MUCH/HOW OFTEN
I TAKE IT FOR:		HOW I FEEL/SIDE EFFECTS
NAME	USE DATES	HOW MUCH/HOW OFTEN
I TAKE IT FOR:		HOW I FEEL/SIDE EFFECTS
NAME	USE DATES	HOW MUCH/HOW OFTEN
I TAKE IT FOR:		HOW I FEEL/SIDE EFFECTS
NAME	USE DATES	HOW MUCH/HOW OFTEN
I TAKE IT FOR:		HOW I FEEL/SIDE EFFECTS

ALLERGIES AND SENSITIVITIES		
DATE	SUBSTANCE	REACTION

Make notes here of any prescription or over-the-counter medications, along with herbal supplements and vitamins, etc. You may want to separate your prescriptions from your supplements.

MEDICATIONS/SUPPLEMENTS		
NAME	USE DATES	HOW MUCH/HOW OFTEN
I TAKE IT FOR:		HOW I FEEL/SIDE EFFECTS
NAME	USE DATES	HOW MUCH/HOW OFTEN
I TAKE IT FOR:		HOW I FEEL/SIDE EFFECTS
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I TAKE IT FOR:		HOW I FEEL/SIDE EFFECTS

ALLERGIES AND SENSITIVITIES		
DATE	SUBSTANCE	REACTION



**Staying Healthy:
Preparing for
the Check-Up**

Use this form to prepare for an annual physical exam. Refer to screening recommendations on the following pages to note those for your age group.

Recommended screening and tests this year:

Problems or concerns about my health that I'd like to discuss:



I'd like to get more information about:

Note health care provider's recommendations:

Medications prescribed, referrals for tests or other specialists:



How will I get test results: _____



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the Check-Up**

Use this form to prepare for an annual physical exam. Refer to screening recommendations on the following pages to note those for your age group.

Recommended screening and tests this year:

Problems or concerns about my health that I'd like to discuss:



I'd like to get more information about:

Note health care provider's recommendations:

Medications prescribed, referrals for tests or other specialists:



How will I get test results: _____

Track how you're doing in each of these key areas. You may want to set new goals or revise old ones.

Healthy Choices

	GOALS
<p>(RECOMMENDED)</p> <p>1. HOW'S MY DIET?</p> <ul style="list-style-type: none"> ● # of meals each day _____ (3) ● # of glasses of water each day (8) ● # of snacks each day _____ ● servings/day: fruit _____ (2-4) vegetable _____ (3-5) poultry, fish, meat, dry beans, nuts _____ (2-3) ● dairy products _____ (2-3) bread, cereal, rice, pasta (6-11) ● % fat intake _____ (<30%) ● Am I getting enough calcium? ____ (1,000-1,500 mg/day) ● Is my weight below average, average or above average? _____ ● Do I have any concerns about my weight? _____ <p>2. PHYSICAL ENDURANCE</p> <ul style="list-style-type: none"> ● How much exercise am I getting? # of times per week _____ How many minutes _____ Type of activity _____ 	

Healthy Choices (cont'd)

	GOALS
<p>2. PHYSICAL ENDURANCE (cont'd)</p> <ul style="list-style-type: none"> ● How much sleep am I getting? Average # of hours I sleep each night _____ # of hours I'd like to sleep per night _____ Describe sleep patterns, problems, disturbances, etc. _____ 	
<p>3. ALCOHOL, TOBACCO AND OTHER DRUGS</p> <ul style="list-style-type: none"> ● Do I smoke _____ # of cigarettes per day _____ Have I ever quit? _____ Would I like to quit? _____ ● Do I drink alcohol? _____ # of drinks per day? _____ # of drinks per week? _____ ● Do I or others worry that my drinking may be a health problem? _____ ● Have I ever quit? _____ ● Would I like to quit or cut down? _____ 	

Healthy Choices (cont'd)

	GOALS
3. ALCOHOL, TOBACCO AND OTHER DRUG (cont'd)	
<ul style="list-style-type: none"> Any other concerns about my current medication or other substance use? _____ Explain nature of use: _____ _____	_____ _____ _____
4. SEXUAL HEALTH	
<ul style="list-style-type: none"> Do I use condoms to prevent infection? _____ Is my sex life satisfying? _____ 	_____ _____
5. SAFETY	
<ul style="list-style-type: none"> Do I wear a seatbelt? _____ Do I wear a helmet on a bike or motorcycle? _____ Do I have a working smoke alarm in my house? _____ Is there a gun in my home? _____ If yes, is it locked? _____ Is it loaded? _____ 	_____ _____ _____ _____ _____
<ul style="list-style-type: none"> Am I in a safe relationship? (Consider your situation without making a notation here.) If anything in your relationship is making you scared or uncomfortable, you can call 1-800-799-7233 (SAFE). 	

Healthy Choices (cont'd)

	GOALS
6. MANAGING HEALTH PROBLEMS	
<ul style="list-style-type: none"> Do I have any chronic health problems (such as diabetes or high blood pressure?) _____ Am I following my doctor's recommendations regarding medication? Diet? Exercise? (etc.) _____ Do I get check-ups as recommended? _____ 	_____ _____ _____ _____
7. STRESS (family, work, self, etc.)	
_____ _____	_____ _____
8. REWARDS AND HEALING ACTIVITIES	
<ul style="list-style-type: none"> What have I done this week to restore my spirit? (examples: meditation, prayer, music...) _____ 	_____ _____ _____ _____

Getting Well:
*Preparing for
the Clinic Visit*

Use this form when you're not feeling well to prepare for a clinic visit. Then use it to take notes while you're there.



What are my symptoms, when did they begin, how have they changed?

Is there anything that makes me feel better or worse?



How is this condition affecting my life right now?

Health care provider's recommendations:

Medications prescribed:



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*Preparing for
the Clinic Visit*

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