

IT'S THE RIGHT TIME

Get Started Today Guide





*At Speaking of Women's Health,
our mission is to "educate women to make
informed decisions about their health,
well-being and personal safety."*

For information to help you "Get Started Today"

- Visit www.speakingofwomenshealth.com
- Watch us Lifetime's Speaking of Women's Health television show on Lifetime's Real Women's Network weekdays from 9 a.m. to 10 a.m. EST
- Pick up free brochures at the education center at Wal-Mart stores across the country
- Read our popular newsletter

***And always, live our motto:
To Be Strong • Be Healthy • Be in Charge***

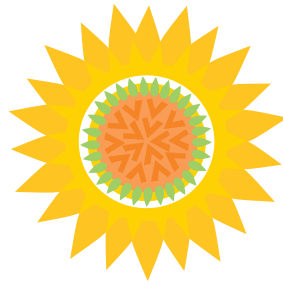
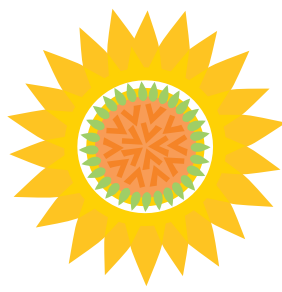


Table of Contents

Introduction	4
Personal Information	5
Physician Information	6
Emergency Information	7
Health Insurance Information	8
Questions To Ask Your Healthcare Provider	9-11
Medications & Surgeries	12-13
Age Appropriate Preventive Care Table	14
Screenings	15-16
Family Information	17
Family Health Care Providers	18
Family Dentists	19
Resource Directory	20



“Get Started Today Guide”

Your “Get Started Today Guide” is intended to help women of all ages and walks of life take charge of their health and well-being. More and more women are taking an active role in seeking information. This action empowers them to make wise choices allowing them to optimize their health. Much progress has been made in the standards of living. We hope to help increase the quality of living and improve the health, well-being and safety of you and your entire family.

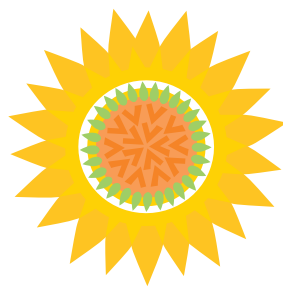
Understanding how to think in terms of “How Well Am I” instead of “How Sick Am I” is so important for every woman. We have taken on so many more roles in our lives than our mothers and grandmothers before us. We are wives, mothers, nurses, money-managers, educators, negotiators, consultants, breadwinners and much more. If we choose to put our health needs last, we are choosing to put ourselves at risk for preventable and detectable diseases.

Use the following information to help you take an active role in living the Speaking of Women’s Health motto: **Be Strong • Be Healthy • Be in Charge.**

Get the most out of your “Get Started Today Guide” by taking a moment to familiarize yourself with it before writing in answers. When completing the questions and forms use pencil to be able to easily update your information as life changes occur. The easiest way to keep your guide updated is to simply bring the guide along with you to your doctor visits.

Wishing you good Health & Happiness

*The Staff at
Speaking of Women's Health*



Personal Information

Your Name

Home Address

Home Phone

Cell Phone

E-mail

Fax

Business Phone

Business Fax

Business E-mail

Your Spouse's/Partner's Name

Cell Phone

E-mail

Business Phone

Business Fax

Business E-mail

Business Name

Business Address

Physician Information

Primary Care Physician:

Address

Office Phone

Answering Service

Hospital Privileges

OB/GYN:

Address

Office Phone

Answering Service

Hospital Privileges

Specialty Physician:

Address

Office Phone

Answering Service

Hospital Privileges

Pharmacy:

Pharmacists

Address

Phone

Fax

Emergency Information

911

Fire

Police

Poison Control

Ambulance

Emergency Contact Persons:

Name

Phone

Name

Phone

Name

Phone

Name

Phone

Local Hospitals:

Name

Phone

Name

Phone

Urgent Care:

Name

Phone

Name

Phone

Pediatrician:

Pediatric Dentist

School

Teacher

Principal

Neighbor

Dad's Office

Mom's Office

Health Insurance

Primary Provider:

Group #

ID #

Address

Phone

Emergency Authorization Phone

Misc.

Second Provider:

Group #

ID #

Address

Phone

Emergency Authorization Phone

Misc.

Questions to Ask Your Health Care Provider

(Make a copy of this form so that you can complete it for each doctor visit.)

Before your visit:

Write down specific questions you want to talk with your healthcare provider about.

Write down all medications and dosages you are presently taking.

(Include over the counter medications and herbal supplements.)

Write down the date of your last menstrual period.

During your visit with your healthcare provider

Talk about your main problem.

Describe symptoms.

Overall physical and emotional state.

Other unrelated symptoms.

continued

Questions to Ask Your Health Care Provider

For your records write down:

Temperature: Blood Pressure: / Weight:

Your diagnosis:

Recommendations:

What your healthcare provider suggested as a self-care plan:

Test or treatment plan prescribed:

Name of drug, test or treatment?

Why are the above needed?

What are the risks if any?

Are there alternatives available?

continued

Questions to Ask Your Health Care Provider

Test or treatment plan prescribed: (continued)

For medications: When do I take them? Do I take them with food?

Will this drug have any effect on other drugs I am presently taking?

For tests: Any preparation needed? Should I eat or drink before the procedure?

Before leaving the offices:

Am I to schedule another appointment?

Should I call the office for my test results?

Is there anything else I should be aware of?

Are there any danger signs I should look for or any reason to call the office?

Other concerns to discuss with your healthcare provider:

Medications

Family Member Name:				
Prescribed Drug	Current Dose	How Many	How Often	Reason for Drug
Known Drug Allergies:				

Family Member Name:				
Prescribed Drug	Current Dose	How Many	How Often	Reason for Drug
Known Drug Allergies:				

Family Member Name:				
Prescribed Drug	Current Dose	How Many	How Often	Reason for Drug
Known Drug Allergies:				

Family Member Name:				
Prescribed Drug	Current Dose	How Many	How Often	Reason for Drug
Known Drug Allergies:				

Family Member Name:				
Prescribed Drug	Current Dose	How Many	How Often	Reason for Drug
Known Drug Allergies:				

Surgeries & Procedures

Family Member Name:			
Surgery/Procedure Performed	Surgeon	Location Performed	Date Performed
Comments:			

Family Member Name:			
Surgery/Procedure Performed	Surgeon	Location Performed	Date Performed
Comments:			

Family Member Name:			
Surgery/Procedure Performed	Surgeon	Location Performed	Date Performed
Comments:			

Family Member Name:			
Surgery/Procedure Performed	Surgeon	Location Performed	Date Performed
Comments:			

Family Member Name:			
Surgery/Procedure Performed	Surgeon	Location Performed	Date Performed
Comments:			

Age Appropriate Preventable Care Table

Health Activity	12-17 Years	18-24 Years	25-39 Years	40-59 Years	60 and Over	Comments
Height, Weight & General Physical	annually	annually	annually	annually	annually	
Blood Pressure/Pulse	every other year	every other year	annually	annually	annually	more often if on birth control pills or have history of high blood pressure
Blood Sugar Evaluation	usually not necessary	usually not necessary	baseline, every 5 years thereafter	baseline, every 5 years thereafter	every other year	
Immunizations	up to date with rubella titer	up to date with rubella titer	tetanus booster every 10 years	tetanus booster every 10 years	influenza vaccine yrly, pneumonia vaccine every 5 yrs	PPD and VDRL yearly if at high risk
Breast Exam by Health Care Provider	teach self breast exam technique	annually•	annually•	annually•	annually•	breast self-exam performed monthly•
Mammography	usually not necessary	usually not necessary	baseline before age 40	annually	annually	recommendations on mammogram may change
Pelvic Exam and Pap Smear	annually if sexually active	annually*	annually*	annually, if not at high risk*	annually, if not at high risk*	check with physician for exam timetable for post-menopausal women
Hemotocrit or Hemoglobin	every other year	every other year; chronic dieters more frequently	every other year	every 5 years	every 3 years	nutritional anemia is common for women who menstruate; uncommon after menopause
Cholesterol/Triglycerides	usually not necessary	baseline age 20 and every 5 years following	5 years	5 years	5 years	per health care provider's discretion
Urinalysis	baseline	every 5 years	every 5 years	every year after 55	every year after 55	more often during pregnancy or if at high risk for diabetes or renal disease
Thyroid	usually not necessary	usually not necessary	usually not necessary	every 5 years	every 5 years	
EKG	usually not necessary	usually not necessary	usually not necessary	baseline	3-5 years	more often if at high risk of heart disease
Stool for Occult Blood	usually not necessary	usually not necessary	usually not necessary	starting at age 50 and annually	annually	
Bone Density	usually not necessary	usually not necessary	usually not necessary	starting at age 50 or if not on HRT	as doctor advises, if post-menopausal	if at risk, as recommended by health care provider
Dental Exam	twice a year	twice a year	twice a year	twice a year	twice a year	
Eye Exam	if need exists	if need exists	if need exists	every 2-4 years [†]	every 1-2 years if 65 or over [†]	more frequent visits if experiencing vision problems
HIV	per risk	per risk	per risk	per risk	per risk	
Skin	every two years	every two years	every year	every year	every year	more frequently if needed
Flexible Sigmoidoscopy	usually not necessary	usually not necessary	usually not necessary	at age 50 and every 5 years after	every 5 years	frequency depends on risk
Colonoscopy	usually not necessary	usually not necessary	usually not necessary	at age 50 and every 10 years after	every 10 years	if at risk as recommended by health care provider

• As recommended by the American Cancer Society *As recommended by the American College of Obstetricians †As recommended by the Academy of Ophthalmology

Screening

Examination/Test	Dates of Screening				
	1	2	3	4	5
Complete History & Physical Exam (including risk factors, exercise, and diet history) Schedule: initial and annually at discretion of clinician	- / - / -	- / - / -	- / - / -	- / - / -	- / - / -
Blood Pressure* Schedule: Annually or more frequently if at risk	- / - / -	- / - / -	- / - / -	- / - / -	- / - / -
Height & Weight Schedule: Periodically	- / - / -	- / - / -	- / - / -	- / - / -	- / - / -
Vision Schedule: Annually at the discretion of clinician	- / - / -	- / - / -	- / - / -	- / - / -	- / - / -
Hearing Schedule: Annually at the discretion of clinician	- / - / -	- / - / -	- / - / -	- / - / -	- / - / -
Dental Inspection Schedule: Periodically	- / - / -	- / - / -	- / - / -	- / - / -	- / - / -
Flexible Sigmoidoscopy Schedule: Every 5 years starting at age 50-	- / - / -	- / - / -	- / - / -	- / - / -	- / - / -
Digital Rectal Exam Schedule: Every year starting at age 50 or as recommended by health care provider	- / - / -	- / - / -	- / - / -	- / - / -	- / - / -
Fecal Occult Blood Schedule: Annually starting at age 50-	- / - / -	- / - / -	- / - / -	- / - / -	- / - / -
Bone Mineral Density Schedule: All females 50 and older if not on HRT or per health care provider's discretion^	- / - / -	- / - / -	- / - / -	- / - / -	- / - / -
Mammogram & Clinical Breast Exam Schedule: Annually beginning at age 40-	- / - / -	- / - / -	- / - / -	- / - / -	- / - / -
Pap Smear & Pelvic Examination Schedule: Annually for women 18 and older and for women who are sexually active-	- / - / -	- / - / -	- / - / -	- / - / -	- / - / -
Thyroid Schedule: Annually starting at age 40-	- / - / -	- / - / -	- / - / -	- / - / -	- / - / -
Skin Cancer Screening Schedule: Annually starting at age 40-	- / - / -	- / - / -	- / - / -	- / - / -	- / - / -
Cholesterol Schedule: Every 5 years starting at age 20 (at discretion of physician if high-risk)	- / - / -	- / - / -	- / - / -	- / - / -	- / - / -
Other	- / - / -	- / - / -	- / - / -	- / - / -	- / - / -

U.S. Preventive Services Task Force recommendation

- American Cancer Society recommendation

+ American Heart Association recommendation

^ National Osteoporosis Foundation guideline

Presence of other risk factors may impact optimal screening frequency recommended for these services.

Screening

Immunization	Dates of Immunization				
Tetanus-Diphtheria Schedule: Every 10 Years	--/--/--	--/--/--	--/--/--	--/--/--	--/--/--
Pneumococcal Schedule: One time dose for persons age 65 and older or those at high risk	--/--/--	--/--/--	--/--/--	--/--/--	--/--/--
Influenza Schedule: Annually age 50 and older and starting younger for those at high risk	--/--/--	--/--/--	--/--/--	--/--/--	--/--/--
Other	--/--/--	--/--/--	--/--/--	--/--/--	--/--/--
	--/--/--	--/--/--	--/--/--	--/--/--	--/--/--

Counseling Topic	Dates of Counseling				
Alcohol and Substance Abuse	--/--/--	--/--/--	--/--/--	--/--/--	--/--/--
Tobacco Cessation	--/--/--	--/--/--	--/--/--	--/--/--	--/--/--
Diet and Exercise Suggested Topics: Limit fat and cholesterol intake Regular physical activity Adequate calcium intake	--/--/--	--/--/--	--/--/--	--/--/--	--/--/--
Hormone Replacement Therapy Discussion	--/--/--	--/--/--	--/--/--	--/--/--	--/--/--
Advanced Directives	--/--/--	--/--/--	--/--/--	--/--/--	--/--/--
Other	--/--/--	--/--/--	--/--/--	--/--/--	--/--/--
	--/--/--	--/--/--	--/--/--	--/--/--	--/--/--

- U.S. Preventive Services Task Force recommendation
- American Cancer Society recommendation
- + American Heart Association recommendation
- ** Center for Disease Control and Prevention recommendation

The above screenings are guidelines only. If you are experiencing any signs or symptoms that are worrisome to you, talk to your health care provider and ask about having a particular screening done.

Family Information

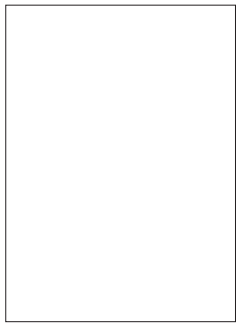
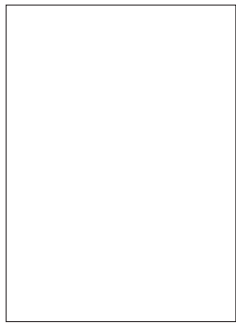


Family Information:

Family Member Name	Birthdate	Social Security #	Allergies	Blood Type
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_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Children's Thumb Print:

Place each child's thumb print in the box below. Press your child's thumb into a black ink pad and then press onto the paper to leave a print.

			
--	--	---	--

Child's Name

Child's Name

Child's Name

Child's Name

Health Club Information:

Name

Address

Phone

Family Health Care Providers

Primary Care Physician:

Address

Office Phone

Answering Service

Hospital Privileges

Primary Care Physician:

Address

Office Phone

Answering Service

Hospital Privileges

Specialty Physician:

Address

Office Phone

Answering Service

Hospital Privileges

Specialty Physician:

Address

Office Phone

Answering Service

Hospital Privileges

Resources

Speaking of Women's Health Web site: www.speakingofwomenshealth.com

Domestic Violence Hotline: 1-800-799-SAFE (7233)

Permission to treat minor: *(copy and attach insurance card)*

To whom it may concern (medical personnel):

Please accept this note and the attached Health Card as authorization to provide my

child _____, with appropriate emergency medical

care in the case that neither I nor his/her father, _____

(phone number: _____) can be reached for consultation for the period

of (start date) _____ to (stop date) _____. He/she will be under

the care of _____, for the purpose of

_____. I trust their judgment in making the

right decision for him/her in my absence.

signed, _____, Mother

(phone number: _____)