

YOUR HEALTH, ORGANIZED

Adult Preventive Care Guide

A practical U.S. reference for adults, caregivers, and conversations with your care team — what is due, what can wait, and what needs a plan built around your history.



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Be Proactive, Not Reactive!

U.S. guidance for adults 18+ · Built from USPSTF, CDC, ACS, NCCN, ADA, AHA/ACC, HRSA, and Medicare sources · Educational reference only — not a diagnosis, treatment plan, or replacement for professional care. In an emergency, call 911. For a mental-health crisis, call or text 988.

START HERE

Use this guide in three steps

A planning reference for adults, caregivers, and care-team conversations. Keep your own record so the right people have the right information.

1

Find your age

Use the one-page chart on **page 3** to see what is typically due for your age group.

2

Check your details

Each section explains who qualifies, how often, and where guideline groups disagree.

3

Make your plan

Fill in **pages 18–20**, bring them to your visit, and update them as results come in.

How to read the symbols

- **Recommended for everyone** in that age group (average risk).
- ◊ **Decide with your clinician** — benefits and harms depend on you.
- ⦿ **Recommended if you have a risk factor**, condition, or specific situation.
- **Not routinely recommended** or not applicable at that age.

What USPSTF grades mean¹

A

Recommended — high certainty of substantial benefit

B

Recommended for the stated group

C

Selective use after discussion

D

Recommend against for that group

I

Insufficient evidence — not proof care is unnecessary

CDC and specialty groups (ACS, NCCN, ADA, AHA/ACC) use their own systems. A recommendation is not a coverage guarantee.

Keep these limits in mind

Screening is for people **without symptoms**. New symptoms or an abnormal result need their own follow-up plan — do not wait for a routine screening date. Apply each recommendation to your organs, medical and family history, medicines, and care goals.²

Bring to every visit

- ☐ Vaccine record and dates
- ☐ Recent screening and lab results
- ☐ Medication and allergy list
- ☐ Family history: who, which condition, age
- ☐ Insurance card and referral details
- ☐ Your plan pages and top questions

Four questions for every visit

What is due?

Which tests or vaccines should I get now?

What can wait?

What is not needed yet, and when should I ask again?

What is different for me?

Does my history change any of these schedules?

Who follows up?

Who will contact me with results, and by when?

911 Immediate danger or a medical emergency

988 Call or text for suicide or mental-health crisis support

1. USPSTF · Grade definitions. <https://www.uspreventiveservicestaskforce.org/uspstf/about-uspstf/methods-and-processes/grade-definitions>

2. USPSTF · Colorectal cancer screening. <https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/colorectal-cancer-screening>

AT A GLANCE

Your age-by-age prevention chart

Find your column, then turn to the page listed for who qualifies, how often, and what to ask.

Service	18-39	40-49	50-64	65-74	75+	Key detail	Pg
VACCINES							
Flu	●	●	●	●	●	Every year; at 65+, high-dose, recombinant, or adjuvanted preferred	4
COVID-19 (2026-27)	●	●	●	●	●	1 dose ages 18-64; 2 doses at 65+, generally 6 months apart	4
Td / Tdap	●	●	●	●	●	Tdap once, then Td or Tdap every 10 years; Tdap each pregnancy	4
Shingles (Shingrix)	⊕	⊕	●	●	●	2 doses at 50+; from 19 if immunocompromised	4
Pneumococcal	⊕	⊕	●	●	●	Routine from 50; younger adults if at risk	4
RSV	⊕ preg.	⊕ preg.	⊕ 50+	⊕	●	One dose: 75+, or 50-74 at increased risk; separate pregnancy pathway	5
Hepatitis B vaccine	●	●	● to 59	⊕	⊕	Routine 19-59; at 60+ with risk factors or on request	5
HPV	● to 26	◇ to 45	—	—	—	Catch-up through 26; ages 27-45 decide with your clinician	5
CANCER SCREENING							
Breast (mammogram) women	⊕	●	●	●	◇	Every 2 years at 40-74 (USPSTF); NCCN advises yearly from 40	6
Cervical with a cervix	● from 21	●	●	◇ stop?	—	21-29: Pap every 3 yrs. 30-65: Pap 3 yrs, HPV 5 yrs, or co-test 5 yrs	7
Colorectal	⊕	● from 45	●	●	◇ 76-85	Start at 45; e.g., FIT yearly or colonoscopy every 10 years	8
Lung (low-dose CT)	—	—	⊕	⊕	⊕ to 80	Yearly at 50-80 with 20+ pack-years who smoke or quit within 15 yrs	9
Prostate (PSA) men	—	—	◇ 55+	◇ to 69	—	USPSTF: decide at 55-69; NCCN discussions start at 45 (40 if higher risk)	9
HEART AND METABOLISM							
Blood pressure	●	●	●	●	●	Yearly at 40+ or if at risk; every 3-5 yrs may suit low-risk 18-39	10
Statin decision	—	⊕	⊕	⊕ to 75	◇	40-75 with a risk factor and 10-year risk of 10% or more	10
Diabetes / prediabetes	⊕ 35+	●	●	●	●	ADA: test all adults by 35, repeat at least every 3 yrs; USPSTF: 35-70 with overweight	10
Aortic aneurysm (AAA) men	—	—	—	⊕	—	One ultrasound, men 65-75 who have ever smoked	10
INFECTIONS							
Hepatitis B test	●	●	●	●	●	At least once for all adults (triple panel); more if ongoing risk	11
Hepatitis C test	●	●	●	●	● to 79	At least once at 18-79; repeat if ongoing exposure	11
HIV test	●	●	●	⊕	⊕	15-65, older if at risk, every pregnancy; ask about PrEP	11
Chlamydia, gonorrhea, syphilis	⊕	⊕	⊕	⊕	⊕	Sexually active women 24 or younger, and anyone at increased risk	11
Latent TB	⊕	⊕	⊕	⊕	⊕	Adults at increased risk of exposure	11
MIND, FUNCTION, AND SENSES							
Depression	●	●	●	●	●	All adults, including pregnancy, postpartum, and older adults	12
Anxiety	●	●	●	—	—	Adults through age 64, including pregnancy and postpartum	12
Alcohol, drugs, tobacco	●	●	●	●	●	Screening questions plus counseling and cessation support	12
Bone density women	⊕	⊕	⊕	●	●	Women 65+; younger postmenopausal women at increased risk	13
Fall prevention	—	—	—	⊕	⊕	Exercise programs at 65+ when fall risk is increased	13
Eye exam	—	●	●	●	●	Baseline at 40; then every 2-4 / 1-3 / 1-2 yrs (AAO)	13
Hearing	—	—	●	●	●	Specialty guideline: screen at 50 and older	13

● Everyone ⊕ If at risk / specific situation ◇ Decide with clinician — Not routine

Average-risk adults without symptoms. Small labels mark where an age band only partly applies. Sources: each section page. 1,2,3

1. CDC · Adult immunization notes. <https://www.cdc.gov/vaccines/hcp/imz-schedules/adult-notes.html>

2. CDC · COVID-19 guidance, September 23, 2026. <https://www.cdc.gov/covid/hcp/vaccine-considerations/routine-guidance.html>

3. USPSTF · A and B recommendations. <https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations>

IMMUNIZATIONS

Vaccines: the routine review

Bring your vaccine record. Prior doses, health conditions, and the product used determine what is due.

Vaccine	Who	How often and what to know
Influenza (flu)	All adults	Every year. At 65+, high-dose inactivated, recombinant, or adjuvanted vaccine is preferred; if none is available, use another age-appropriate flu vaccine. ¹
COVID-19 2026–27	All adults 18+ (CDC, Sept 23, 2026)	Not immunocompromised: ages 18–64 one dose; 65+ two doses , generally six months apart. Product-specific minimum intervals and prior doses matter. ²
Td / Tdap	All adults	After a complete primary series: at least one Tdap if not already given, then Td or Tdap every 10 years . An incomplete or unknown primary series needs a catch-up plan. Wound care can require an earlier dose. Tdap during each pregnancy. ¹
Shingles (Shingrix)	All adults 50+; adults 19+ who are or will be immunocompromised	Two doses , usually 2–6 months apart (timing may differ with immune compromise). A previous shingles episode does not replace vaccination. ¹
Pneumococcal	All adults 50+; younger adults with risk conditions	No prior conjugate vaccine or unknown history: PCV20 or PCV21 alone, or PCV15 followed by PPSV23 . Prior vaccine history changes the plan. ¹

COVID-19: confirm the plan before vaccination

Ask the vaccinator to confirm the current product, interval, immune-status schedule, and FDA indication. CDC identifies some uses as off-label. Its general schedule and a table-date label retain older dates; confirm the current-season plan using the COVID-specific guidance.^{2,1}

ASK YOUR CLINICIAN

? Based on my record, which of these am I due for today?

? Can I get more than one vaccine at this visit?

? Which product are you using, and when is my next dose?

Record it: write each dose on the vaccine log on **page 19** — date, product, and where it was given.

1. CDC · Adult immunization notes. <https://www.cdc.gov/vaccines/hcp/immunization/adult-immunization/adult-immunization-notes.html>

2. CDC · COVID-19 guidance, September 23, 2026. <https://www.cdc.gov/covid/hcp/vaccine-considerations/routine-guidance.html>

IMMUNIZATIONS

Vaccines: risk and catch-up

Do not assume you need every vaccine below. Review immunity, exposures, travel, and special situations.

Respiratory syncytial virus (RSV)

1 dose · 75+ or 50–74 at risk

One dose for adults 75+ and adults 50–74 at increased risk, if not previously vaccinated — this includes eligible ages 65–74. RSV vaccination is **not currently annual**. Pregnancy follows a separate pathway on page 14.¹

Hepatitis A and hepatitis B

HepB routine 19–59

HepA: on request or for a risk indication; the series depends on the product. **HepB:** routine for ages 19–59. At 60+, vaccinate with risk factors or on request; others may also receive it. Hepatitis B *screening* is separate (page 11).¹

Human papillomavirus (HPV)

Through 26 · discuss 27–45

Complete catch-up vaccination **through age 26**. Ages 27–45: decide with your clinician. The number of doses depends on age at the first dose and immune status. HPV vaccination is delayed during pregnancy.¹

MMR and chickenpox (varicella)

Live vaccines

MMR: generally 1–2 doses without evidence of immunity. Varicella: 2 doses without evidence of immunity. Birth-year rules have exceptions; have your record reviewed. These live vaccines are **not given during pregnancy** and can be unsafe with severe immune suppression.¹

Meningococcal, Hib, mpox, and polio

Risk-based

MenACWY is risk-based, including certain medical, college, military, and travel situations. MenB can also be a shared decision at ages 16–23. Hib, mpox, and polio depend on specific risks and prior doses; adults with incomplete polio vaccination should complete the series.¹

Before travel or immune-suppressing treatment

Plan ahead

Bring your itinerary and treatment dates. Ask about vaccine timing, live-vaccine restrictions, and boosters. An interrupted series usually **does not need to be restarted**.¹

ASK YOUR CLINICIAN

? Do my health conditions, job, or travel plans add any vaccines?

? Do I have proof of immunity, or do I need a blood test or dose?

? If I missed a dose in a series, what is the catch-up plan?

1. CDC · Adult immunization notes. <https://www.cdc.gov/vaccines/hcp/imz-schedules/adult-notes.html>

CANCER PREVENTION

Breast screening and inherited risk

Average-risk screening and high-risk surveillance are different plans.

PATHWAY A · USPSTF

Every 2 years

mammogram · ages 40–74 · Grade B

Discuss what is appropriate beyond this age range rather than automatically continuing the same interval.¹

PATHWAY B · NCCN 2026

Every year

mammogram · from age 40

Also recommends a breast-risk assessment by age 25. Discuss which pathway fits your health, history, and preferences — rather than combining the two.²

Ask for a risk assessment

Tell your clinician about cancers on both sides of your family, ages at diagnosis, genetic test results, prior chest radiation, and prior breast biopsy findings. Some higher-risk people need MRI as well as mammography; start ages and timing depend on the specific risk.^{2,3}

Genetic counseling is not one rule for everyone

USPSTF recommends a brief familial-risk assessment for women with a relevant personal or family history of breast, ovarian, tubal, or peritoneal cancer, or ancestry associated with BRCA variants. A positive assessment leads to counseling and, when indicated, testing (Grade B). Broader hereditary pathways can apply to other cancers and to men.^{1,3}

Risk-reducing medicine

Grade B · 35+

For women 35+ at increased breast-cancer risk and low risk of medication harms, discuss preventive medication with the clinician (USPSTF Grade B). Do not start a medicine based only on a risk score.¹

An imaging-based risk score is not a diagnosis

NCCN's 2026 patient guide treats a five-year risk of 1.7% or higher from an imaging-based model as an increased-risk category. Ask what the result means and whether more screening is appropriate; do not use a score alone to choose a test or medicine.²

ASK YOUR CLINICIAN

? Which pathway — every year or every two years — fits my history?

? Is my risk high enough to add MRI or see a genetic counselor?

? Who will call me with the result, and when?

1. USPSTF · A and B recommendations. <https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations>

2. NCCN · Breast screening patient guide, 2026. <https://www.nccn.org/patients/guidelines/content/PDF/breastcancerscreening-patient.pdf>

3. NCCN · Hereditary cancer patient guide, 2026. <https://www.nccn.org/patients/guidelines/content/PDF/genetics-patient.pdf>

CANCER PREVENTION

Cervical cancer screening

Use the pathway your clinician recommends. This applies to people with a cervix.

Age	USPSTF (final, 2018) ¹	ACS alternative ²
21–24	Pap test every 3 years (Grade A)	Screening starts at 25
25–29	Pap test every 3 years (Grade A)	Preferred: clinician-collected primary HPV test every 5 years Alternative: self-collected vaginal HPV test every 3 years (approved, professionally ordered)
30–65	Choose one (Grade A): • Pap every 3 years • Primary high-risk HPV every 5 years • HPV + Pap (co-testing) every 5 years	Also: co-testing every 5 years; Pap every 3 years if others unavailable
Over 65	Stopping requires adequate prior screening and no high-risk history.	

The current final USPSTF statement remains the 2018 recommendation; an update in progress is not a final replacement. Having an HPV vaccine does not remove the need for screening.¹

After a hysterectomy

Grade D

After removal of the cervix, screening is generally not recommended without a history of high-grade cervical precancer or cervical cancer (USPSTF Grade D for these groups).¹

A different plan may be needed

Prior abnormal results, cervical precancer or cancer, HIV or other immune compromise, or prenatal DES exposure require individualized follow-up. New symptoms are not managed by a routine screening interval.¹

Self-collection and coverage are separate

Plan years from 2027

HRSA's updated guideline includes patient-collected HPV testing for average-risk ages 30–65, effective for applicable plan years starting in 2027. Ask what is available and covered now; not every home test is covered.³

ASK YOUR CLINICIAN

- ? Which test am I getting, and when is the next one due?
- ? Is self-collection an option for me, and is it covered?
- ? Do my past results mean I need a different schedule?

1. USPSTF · Cervical cancer, final recommendation. <https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/cervical-cancer-screening>

2. ACS · Cervical cancer screening. <https://www.cancer.org/cancer/types/cervical-cancer/detection-diagnosis-staging/cervical-cancer-screening-guidelines.html>

3. HRSA · Women's preventive services. <https://www.hrsa.gov/womens-guidelines>

CANCER PREVENTION

Colorectal cancer screening

The best test is one you will complete — with a plan for any follow-up.

Under 45 · average risk: not routine	45–49 · B	50–75 · Grade A	76–85 · C
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USPSTF, average risk. Ages 76–85: decide individually based on health, past screening, and preferences. This is not the pathway for symptoms, prior colorectal cancer, certain polyps, inflammatory bowel disease, or hereditary syndromes.¹

Test	How often	Notes
FIT or high-sensitivity stool blood test	Every year	At home; abnormal result needs colonoscopy ¹
Stool DNA-FIT	Every 1–3 years	At home ¹
Multitarget stool RNA or updated stool DNA (ACS 2026)	Every 3 years	Included in ACS 2026 options ²
CT colonography	Every 5 years	Imaging; abnormal result needs colonoscopy ¹
Colonoscopy	Every 10 years	Bowel prep, sedation, and a ride home ¹
Flexible sigmoidoscopy	Own schedule	Ask your clinician ¹
Blood-based test	—	Not a preferred first choice; ACS reserves it for people who decline or do not complete stool or visual tests ²

Intervals assume normal results and average risk.

An abnormal non-colonoscopy test needs follow-up

An abnormal stool test, CT colonography, or flexible sigmoidoscopy generally needs **colonoscopy** to complete screening. Do not simply repeat a stool test to dismiss an abnormal result.¹

Family history or higher risk

Ask for a separate, documented schedule. There is no single “start 10–25 years earlier” rule that works for Lynch syndrome, inflammatory bowel disease, and every family history.^{1,2}

ASK YOUR CLINICIAN

? Which test can I realistically complete — and what does it cost?

? What are the prep, time-off, and ride-home requirements?

? Who calls me with the result, and what happens if it is abnormal?

1. USPSTF · Colorectal cancer screening. <https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/colorectal-cancer-screening>

2. ACS · Colorectal guideline update, May 27, 2026. <https://pressroom.cancer.org/colorectal-cancer-screening-guideline-update-2026>

CANCER PREVENTION

Lung, prostate, and skin

Keep guideline pathways separate, and choose one with your clinician.

Lung · low-dose CT every year

USPSTF · GRADE B

Ages 50–80 with at least 20 pack-years who currently smoke or quit within the past 15 years. Stop after 15 years without smoking, or when health substantially limits life expectancy or the ability or willingness to have curative lung surgery.¹

ACS ALTERNATIVE

Also **ages 50–80 and at least 20 pack-years**, but **no years-since-quit cutoff**. Not advised when health greatly limits life expectancy or the ability or willingness to receive treatment. Check insurance eligibility separately.²

Pack-years = packs smoked per day × years smoked. Ask your clinician to calculate yours.

Prostate · decide before ordering a PSA

USPSTF

Ages 55–69: discuss the small potential benefit and possible harms — false positives, overdiagnosis, and treatment effects (Grade C). Recommends against routine PSA screening at **70+** (Grade D). Family history and ancestry belong in the discussion.³

NCCN 2026

Starts screening discussions at **45 for average risk** and **40 for higher risk**. Screening after 75 is reserved for selected very healthy people expecting at least 10 more years of life. Repeat testing depends on PSA, risk factors, and exam findings.⁴

Skin · symptoms versus routine screening

Routine skin checks

I statement

USPSTF finds insufficient evidence for routine clinician skin screening in people without symptoms (I statement). This does not apply to a suspicious or changing lesion or certain high-risk histories.⁵

Sun protection

Grade B · to 24

UV-protection counseling is recommended through age 24 for people with fair skin (Grade B); counseling at older ages is selective. Show any new, changing, or unusual spot to a clinician.⁵

1. USPSTF · A and B recommendations. <https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations>

2. ACS · Lung cancer guideline. <https://pressroom.cancer.org/releases?item=1274>

3. USPSTF · Prostate cancer screening. <https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/prostate-cancer-screening>

4. NCCN · Prostate screening patient guide, 2026. <https://www.nccn.org/patients/guidelines/content/PDF/prostate-screening-patient.pdf>

5. USPSTF · Skin cancer screening. <https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/skin-cancer-screening>

PREVENTION BEYOND CANCER

Heart and metabolic health

Screening identifies possible risk. A clinician interprets results and sets your treatment goals.

Blood pressure

Grade A · 18+

Screen adults 18+ (USPSTF Grade A): generally **yearly at 40+** or with increased risk; every 3–5 years may suit low-risk ages 18–39 with prior normal readings. Confirm a new diagnosis outside the clinic before routine treatment; urgent situations need prompt assessment.¹

Cholesterol and cardiovascular risk

Grade B · 40–75

USPSTF recommends a statin at ages 40–75 with at least one cardiovascular risk factor and an estimated 10-year risk of 10% or more (Grade B). Discuss benefits and harms; this is not a self-treatment threshold.²

AHA/ACC 2026 lipid guidance

Lp(a) once

The specialty guideline uses PREVENT-ASCVD risk equations and recommends measuring **lipoprotein(a), or Lp(a), at least once in a lifetime**. ApoB testing is selective. These are specialty recommendations, not new USPSTF grades.³

Diabetes: two pathways

By 35 · every 3 yrs

USPSTF: screen ages 35–70 with overweight or obesity (Grade B). **ADA 2026:** begin by 35 for other adults too; consider earlier testing with overweight or obesity plus risk factors. With normal results, repeat at least every 3 years, sooner if risk changes.^{2,4}

Abdominal aortic aneurysm (AAA)

Men 65–75

USPSTF recommends **one ultrasound** for men ages 65–75 who have ever smoked (Grade B). Other groups need a separate assessment rather than automatic use of this rule.²

Weight, food, and activity

Grade B

Ask about intensive behavioral support if your BMI is 30+ (Grade B), and food and activity counseling if you have cardiovascular risk factors (Grade B). Choose a plan that fits your abilities and resources.²

MY NUMBERS

Blood pressure

LDL / Lp(a)

A1c or glucose

Weight / BMI

Date

Your goals are set with your clinician — the numbers on this page are screening thresholds, not personal targets.

ASK YOUR CLINICIAN

? Should I check my blood pressure at home, and how?

? What is my 10-year heart risk, and has Lp(a) ever been measured?

? When should I next be tested for diabetes?

1. USPSTF · Blood pressure screening. <https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/hypertension-in-adults-screening>

2. USPSTF · A and B recommendations. <https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations>

3. AHA/ACC · Dyslipidemia guideline, 2026. <https://professional.heart.org/en/science-news/2026-guideline-on-the-management-of-dyslipidemia>

4. ADA · Standards of Care, 2026. https://diabetesjournals.org/care/article/49/Supplement_1/S27/163926/2-Diagnosis-and-Classification-of-Diabetes

PREVENTION BEYOND CANCER

Infection screening

Repeat testing depends on pregnancy, exposure, and ongoing risk.

Hepatitis B: the one-time adult screen

Once · all adults

CDC: screen all adults 18+ at least once with HBsAg, anti-HBs, and total anti-HBc (the triple panel). Ongoing risk and pregnancy can require more testing. **USPSTF:** its separate Grade B recommendation targets people at increased risk. ^{1,2}

Hepatitis C

Grade B · 18–79

USPSTF recommends screening **ages 18–79** (Grade B). Ask whether ongoing exposure, such as injection drug use, calls for repeat testing. ^{2,3}

HIV testing and prevention

Grade A

Screen **ages 15–65**, younger or older people at increased risk, and all pregnant people (USPSTF Grade A). People at increased risk of acquiring HIV should discuss **PrEP**, a prevention medicine (Grade A). ²

Syphilis, chlamydia, and gonorrhea

Screen for syphilis when at increased risk (Grade A). For chlamydia and gonorrhea, USPSTF recommends screening sexually active women 24 or younger and those 25+ at increased risk (Grade B). CDC recommends annual screening for these groups; exposure sites and other risks can change the plan. ^{2,4}

Latent tuberculosis (TB)

Grade B · at risk

Screen adults without symptoms who are at increased risk (USPSTF Grade B). Discuss birth or residence in higher-prevalence countries, TB exposure, and higher-risk congregate settings. Frequency depends on continued risk. ^{2,3}

Make testing easier

Ask which tests are due, when results will arrive, and who will explain them. Bring prior vaccination and test records. Testing and vaccination are different steps — a vaccine does not replace a needed test.

ASK YOUR CLINICIAN

- ? Have I ever had the one-time hepatitis B and hepatitis C tests?
- ? Based on my situation, how often should I be tested for HIV and STIs?
- ? Would PrEP make sense for me?

1. CDC · Hepatitis B screening and testing. <https://www.cdc.gov/hepatitis-b/hcp/diagnosis-testing/index.html>

2. USPSTF · A and B recommendations. <https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations>

3. WPSI · Clinical summary tables, May 2026. <https://www.womenspreventivehealth.org/wp-content/uploads/2026-Clinical-Summary-Tables-FINAL.pdf>

4. CDC · STI screening recommendations. <https://www.cdc.gov/std/treatment-guidelines/screening-recommendations.htm>

PREVENTION BEYOND CANCER

Mental health and well-being

Your mind is part of your health. Screening opens the conversation.

988 In the U.S., call or text 988 for suicide or mental-health crisis support.¹

911 Call 911 for immediate danger or a medical emergency.

Depression and anxiety

Grade B

USPSTF recommends adult depression screening, including pregnancy, postpartum, and older adults (Grade B). Anxiety screening is recommended through age 64, including pregnancy and postpartum (Grade B). Positive results need assessment and access to care.^{2,3}

Suicide risk is a separate recommendation

I statement

USPSTF finds insufficient evidence for universal suicide-risk screening in adults without recognized symptoms (I statement). This does **not** mean ignoring suicidal thoughts or delaying care when someone is in distress.³

Alcohol, drug use, and tobacco

Grades A and B

Screen adults for unhealthy alcohol use and offer counseling when indicated (Grade B). Drug-use screening asks questions — not routine urine testing — and requires access to diagnosis and treatment (Grade B). Tobacco cessation support is recommended (Grade A); pregnancy changes medicine choices.^{2,4}

Safety at home and in relationships

Grade B

USPSTF recommends intimate-partner-violence screening for women of reproductive age, including pregnancy and postpartum, with access to appropriate ongoing support (Grade B). Ask to speak privately if that feels safer.²

A questionnaire is a starting point, not a diagnosis

Short screening forms help your care team notice what to ask about next. Answer honestly; your clinician uses the answers to decide whether a fuller assessment, support, or referral would help.

ASK YOUR CLINICIAN

? Can we talk about my mood, stress, sleep, or drinking privately?

? If I screen positive, what support or referral is available — and is it covered?

? What help is there for quitting tobacco or vaping?

1. SAMHSA · 988 crisis support. <https://www.samhsa.gov/mental-health/988/faqs>

2. USPSTF · A and B recommendations. <https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations>

3. USPSTF · Depression and suicide-risk screening. <https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/screening-depression-suicide-risk-adults>

4. USPSTF · Unhealthy drug use screening. <https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/drug-use-illicit-screening>

FUNCTION AND INDEPENDENCE

Bones, falls, eyes, ears, and teeth

Do not let an age-based checklist replace attention to a new symptom or a change in function.

BONE DENSITY · USPSTF

Screen **women 65+** and postmenopausal women under 65 at increased fracture risk after clinical assessment (Grade B). Evidence for screening men is insufficient (I).¹

BONE DENSITY · BHOF

Test **men 70+**, or men 50–69 with risk factors. Prior fractures, bone-affecting illness, or medicines require individual review.²

Eye exams for adults without symptoms or risk factors · AAO³

At 40 · baseline exam

40–54 · every 2–4 yrs

55–64 · every 1–3 yrs

65+ · every 1–2 yrs

Eye disease, diabetes, symptoms, or other risks can require earlier or more frequent care.

Falls

Grade B · 65+

For community-dwelling adults 65+ at increased fall risk, USPSTF recommends **exercise interventions** (Grade B). Ask about balance, medicines, vision, and home hazards when planning prevention.⁴

Hearing · AAO-HNSF

50+

The specialty guideline recommends hearing-loss screening at **age 50 and older**. Ask about testing and follow-up if you notice trouble hearing or understanding speech; this is separate from any USPSTF grade.⁵

Dental and mouth care

Every day

Arrange dental visits on a schedule based on your needs, not an assumed universal six-month rule. The American Dental Association recommends **brushing twice daily for two minutes** with fluoride toothpaste and cleaning between teeth daily.⁶

ASK YOUR CLINICIAN

? Am I due for a bone density test, and how is my fracture risk?

? Could any of my medicines raise my risk of falling?

? When should I have my eyes and hearing checked?

1. USPSTF · Osteoporosis screening, 2025. <https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/osteoporosis-screening>

2. BHOF · Bone density testing. <https://www.bonehealthandosteoporosis.org/patients/diagnosis-information/bone-density-examtesting/>

3. American Academy of Ophthalmology · Eye examination frequency. <https://www.aao.org/education/clinical-statement/frequency-of-ocular-examination>

4. WPSI · Clinical summary tables, May 2026. <https://www.womenspreventivehealth.org/wp-content/uploads/2026-Clinical-Summary-Tables-FINAL.pdf>

5. AAO-HNSF · Age-related hearing loss guideline. <https://www.entnet.org/resource/new-clinical-practice-guideline-provides-evidence-based-recommendations-for-age-related-hearing-loss-arhl/>

6. American Dental Association · Home care. <https://www.ada.org/resources/ada-library/oral-health-topics/home-care>

A SEPARATE PREVENTION PATHWAY

Pregnancy and postpartum

A conversation-starter for your prenatal or postpartum care team — not a complete prenatal schedule.

Before pregnancy

If you plan to or could become pregnant, take **400–800 mcg folic acid daily** (USPSTF Grade A). Ask whether your history or medicines call for a different dose. Review medicines and vaccines before conception.¹

Early and ongoing

Discuss HIV, syphilis, hepatitis B, urine-culture screening, and Rh(D) blood typing/antibody testing. Blood pressure checks throughout pregnancy. Gestational-diabetes screening at **24 weeks or later**; your team may test earlier.¹

Weeks 27–36

Tdap each pregnancy, preferably early in weeks 27–36. **Maternal RSV (Abrysvo)**: 32 weeks 0 days through 36 weeks 6 days, generally September–January in most of the continental U.S.²

After delivery

After gestational diabetes: ADA recommends a 75-g oral glucose tolerance test at **4–12 weeks postpartum**, then lifelong testing every 1–3 years. Schedule it before delivery if possible.³

Vaccine and medicine safety

MMR and varicella are not given during pregnancy. Ask about flu and current COVID-19 vaccination. Low-dose aspirin for selected pregnancies at high preeclampsia risk is used after 12 weeks under clinician direction — **do not start it yourself**.^{2,4,1}

RSV: one pregnancy pathway

After a prior maternal RSV dose, repeat doses in later pregnancies are not currently recommended; ask about infant protection instead.²

Mental health and feeding support

Ask about depression and anxiety, breastfeeding support if desired, and preventive counseling when at increased risk of perinatal depression. Keep your postpartum appointments.¹

ASK YOUR CLINICIAN

- ? Which tests and vaccines are due at this stage of my pregnancy?
- ? Are any of my current medicines a concern?
- ? What postpartum checks should I schedule now?

1. USPSTF · A and B recommendations. <https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations>

2. CDC · Adult immunization notes. <https://www.cdc.gov/vaccines/hcp/imz-schedules/adult-notes.html>

3. ADA · Standards of Care, 2026. https://diabetesjournals.org/care/article/49/Supplement_1/S27/163926/2-Diagnosis-and-Classification-of-Diabetes

4. CDC · COVID-19 guidance, September 23, 2026. <https://www.cdc.gov/covid/hcp/vaccine-considerations/routine-guidance.html>

RISK-SPECIFIC CARE

When you need a personalized plan

Tell your clinician which situations apply. The next step depends on the condition, not just the age column.

HIV or immune-suppressing treatment

Review vaccine timing and live-vaccine restrictions. Shingrix can be recommended from age 19 for immune compromise. MMR and varicella eligibility in HIV depends on immunity and immune-cell criteria; these vaccines are not appropriate for everyone with HIV.¹

No spleen, sickle cell disease, cochlear implant, or CSF leak

These can change vaccine recommendations. Asplenia or sickle cell disease can require meningococcal, Hib, and pneumococcal protection. A cochlear implant or cerebrospinal-fluid leak can change the pneumococcal schedule. Prior doses still matter.¹

Chronic heart, lung, kidney, or liver disease; diabetes

Review disease-specific vaccines and monitoring. RSV eligibility at 50–74 depends on increased-risk criteria; isolated high blood pressure alone is not a qualifying RSV risk. Existing disease needs a plan beyond screening.¹

Family cancer history or a genetic finding

Bring the actual report and relatives' cancer types and diagnosis ages. The gene and family pattern determine which organs need surveillance. Do not assume every BRCA finding requires early colonoscopy or the same breast or prostate schedule.²

Sexual exposure, substance use, travel, or congregate living

Discuss relevant hepatitis, HIV, STI, TB, and vaccine needs. Not every exposure calls for every test. Ask about throat or rectal testing, PrEP, and mpox vaccination when relevant.^{1,3}

Symptoms change the task

Report unexpected bleeding or spotting after menopause rather than waiting for a checkup. ACS recommends symptom education, not routine endometrial screening for average-risk people.⁴

Which of these apply to me?

- | | |
|--|---|
| ☐ Immune-suppressing condition or treatment | ☐ No spleen or sickle cell disease |
| ☐ Chronic heart, lung, kidney, or liver disease | ☐ Diabetes |
| ☐ Family cancer history or genetic result | ☐ Upcoming travel |
| ☐ New or changing symptoms | ☐ Pregnant or planning pregnancy |

1. CDC · Adult immunization notes. <https://www.cdc.gov/vaccines/hcp/imz-schedules/adult-notes.html>

2. NCCN · Hereditary cancer patient guide, 2026. <https://www.nccn.org/patients/guidelines/content/PDF/genetics-patient.pdf>

3. CDC · STI screening recommendations. <https://www.cdc.gov/std/treatment-guidelines/screening-recommendations.htm>

4. ACS · Endometrial cancer symptom education. <https://www.cancer.org/health-care-professionals/american-cancer-society-prevention-early-detection-guidelines/endometrial-cancer-screening-guidelines.html>

PAYING FOR PREVENTION

Understanding your benefits

Know what is covered, what could cost extra, and what to ask before you book.

Medicare Annual Wellness Visit

Every 12 months

This Part B benefit develops or updates a personalized prevention plan. It is **not a routine physical exam**. It is generally covered once every 12 months after eligibility requirements are met; the first visit cannot occur within 12 months of Part B enrollment or a Welcome to Medicare visit.¹

What could cost extra?

You pay nothing for the covered wellness visit when the provider accepts assignment. Added tests or services may have costs, and a routine physical is not covered under this benefit. Ask which parts of a combined visit may be billed separately.¹

HRSA-supported women's preventive services

Include well-woman care, contraceptive services, breastfeeding support, and other listed services. Coverage rules include plan-year timing and exceptions. HRSA's updated cervical guideline applies beginning with plan years starting in 2027; a guideline update is not automatically an immediate benefit change.²

Navigation help

HRSA-supported guidance includes needs-based navigation for breast and cervical screening and follow-up. Ask about language support, transportation, scheduling, and referrals that could help you complete care; check availability and coverage with your plan.²

Other HRSA-supported services to discuss

WPSI recommends annual urinary-incontinence screening for women and weight-gain-prevention counseling for women ages 40–60 with BMI 18.5–29.9. These are clinical recommendations; check coverage rules separately.²

Questions to ask the plan and the office

1. Is this **screening** or **diagnostic** care?
2. Are the clinician and facility **in network**?
3. Does my age, history, interval, or test type meet **coverage rules**?
4. Is a **referral or prior authorization** needed?
5. What could I owe for the visit, lab, imaging, anesthesia, or follow-up?

Never delay urgent care to resolve a coverage question. Ask about coverage before booking routine care.

1. Medicare · Yearly wellness visits. <https://www.medicare.gov/coverage/yearly-wellness-visits>

2. HRSA · Women's preventive services. <https://www.hrsa.gov/womens-guidelines>

QUALITY MEASURES, NOT YOUR CARE PLAN

Understanding quality measures

A reminder or score can flag a care gap. It does not establish a diagnosis, an individual goal, or an insurance benefit.

HEDIS and CMS Star Ratings are different systems

NCQA's HEDIS measures assess quality using defined populations and measurement periods. CMS Star Ratings use selected measures plus other plan-performance information. The 2026 Star list includes breast and colorectal screening, flu vaccination, medication review, pain assessment, and other measures; not every HEDIS measure is a Star measure.^{1,2}

Vaccination measures are broader than three shots

NCQA's AIS-E includes influenza, Td/Tdap, zoster, pneumococcal, hepatitis B, and COVID-19 indicators. HEDIS MY2026 added a COVID-19 indicator for people 65+. This is a measurement definition, not a replacement for CDC's clinical schedule.^{3,1}

A scoring threshold is not a treatment goal

NCQA's diabetes glycemic-status measure reports indicators below 8% and above 9%. These are not a universal personal A1c target. Agree on your own glucose, blood pressure, and cholesterol goals with your clinician.⁴

Prescription fills do not prove doses were taken

Medication-adherence measures such as proportion of days covered use medication-supply information. They estimate coverage of days, not direct observation. Tell the care team about side effects, missed doses, costs, or medicines stopped by a clinician.⁵

Dates and populations matter

A HEDIS measurement year and a CMS rating year are not interchangeable. Read the named program and version before using a measure as a checklist; eligibility and timing can differ from clinical recommendations.^{1,2}

Got a reminder letter or "care gap" call?

Treat it as a prompt to check your record, not a diagnosis or an order. Compare it to your plan on page 18, then ask your clinician whether the service is actually due for you — or already done and just not recorded.

1. NCQA · HEDIS measurement year 2026 changes. <https://www.ncqa.org/blog/hedis-my-2026-whats-new-whats-changed-whats-retired/>

2. CMS · 2026 Star Ratings measures. <https://www.cms.gov/files/document/2026-star-ratings-measures.pdf>

3. NCQA · Adult Immunization Status. <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/adult-immunization-status-ais-e/>

4. NCQA · Glycemic Status Assessment. <https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/glycemic-status-assessment-for-patients-with-diabetes-gsd/>

5. PQA · Medication-use quality measures. <https://www.pqa.org/measures/measures-resources/>

TAKE THIS PAGE TO YOUR VISIT

My prevention plan

Name

Date of birth

Updated / visit date

Primary clinician / office

Office phone

Patient portal / ID

Test, vaccine, or next action	Due date	Done date	Result / follow-up

My main question for this visit

Who will contact me about results, and by when?

Complete this with your care team; “not due” may be the right answer. Save a copy before typing in a PDF reader that supports forms, or print and write.

KEEP YOUR OWN RECORD

My vaccine and screening record

Write results as your clinician reports them. Do not interpret them here — ask what each one means for you.

Vaccine log

Vaccine	Date given	Product / dose number	Where given / next due
Flu			
COVID-19			
Td / Tdap			
Shingles (Shingrix)			
Pneumococcal			
RSV			
Hepatitis B			
Other			

Screening log

Screening	Date	Test used / result	Next due
Blood pressure			
Cholesterol / Lp(a)			
Diabetes (A1c)			
Colorectal			
Breast			
Cervical			
Hepatitis B / C, HIV			
Bone density			
Other			

PREPARE FOR YOUR VISIT

My care team and visit notes

My care team

Role	Name / office	Phone
Primary care		
Specialist		
Specialist		
Pharmacy		
Insurance plan		
Caregiver / health care agent		
Emergency contact		

Family health history

Relatives with cancer, heart disease, diabetes, or other conditions — include which side of the family and age at diagnosis

Before my next visit

Top three questions

New symptoms or changes since last visit

Use your record safely

Keep completed pages in a protected place. Share only with the people you choose, and ask the receiving office how to send health information securely. Keep a current copy and a backup.

MORE ROOM TO STAY ORGANIZED

Keep everything in one place

This guide is designed to be useful on its own. For more detailed planning and record keeping, explore SynquUp books, workbooks, and Emergency Life Binders at **chuckkinney.com**, and health-navigation resources at **SynquUp.com**.

About this guide

Recommendations summarize U.S. guidance from USPSTF, CDC, ACS, NCCN, ADA, AHA/ACC, AAO, AAO-HNSF, BHO, HRSA, WPSI, NCQA, CMS, and Medicare as checked September 27–28, 2026, with vaccine guidance rechecked October 26, 2026. Guidance changes; each page lists its sources with links.

Important

This is an educational reference. It is not a diagnosis, treatment plan, coverage determination, or replacement for professional care. Apply it with your clinician to your own history, medicines, and goals. In an emergency, call 911. For a mental-health crisis, call or text 988.

Trusted places to check for updates

USPSTF A and B recommendations

uspreventiveservicestaskforce.org

CDC adult immunization notes

cdc.gov/vaccines

Medicare yearly wellness visits

medicare.gov

HRSA women's preventive services

hrsa.gov

988 Suicide & Crisis Lifeline

Call or text 988

SynquUp resources

SynquUp.com · chuckkinney.com