Are You at Risk for Cardiovascular Disease?

Your chances of suffering an early heart attack or stroke depend on a variety of factors, many of which are under your control. The best time to identify your risk factors and change your behavior to lower your risk is when you are young. You can significantly affect your future health and quality of life if you adopt healthy behaviors. To help identify your risk factors, circle the response for each risk category that best describes you.

1. Gender and Age
   0 Female age 55 or younger; male age 45 or younger
   2 Female over age 55 or male over age 45

2. Heredity
   0 Neither parent suffered a heart attack or stroke before age 60.
   3 One parent suffered a heart attack or stroke before age 60.
   7 Both parents suffered a heart attack or stroke before age 60.

3. Smoking
   0 Never smoked
   3 Quit more than 2 years ago and lifetime smoking is less than 5 pack-years*
   6 Quit less than 2 years ago and/or lifetime smoking is greater than 5 pack-years*
   8 Smoke less than 1/2 pack per day
   13 Smoke more than 1/2 pack per day
   15 Smoke more than 1 pack per day

4. Environmental Tobacco Smoke
   0 Do not live or work with smokers
   2 Exposed to ETS at work
   3 Live with smoker
   4 Both live and work with smokers

5. Blood Pressure
   The average of the last three readings:
   0 120/80 or below
   1 121/81 to 130/85
   3 Don’t know
   5 131/86 to 150/90
   9 151/91 to 170/100
   13 Above 170/100

6. Total Cholesterol
   0 Lower than 190
   1 190 to 210
   2 Don’t know
   3 211 to 240
   4 241 to 270
   5 271 to 300
   6 Over 300

7. HDL Cholesterol
   The average of the last three readings:
   0 Over 60 mg/dl
   1 55 to 60
   2 Don’t know HDL
   3 45 to 54
   5 35 to 44
   7 25 to 34
   12 Lower than 25

8. Exercise
   0 Exercise three times a week
   1 Exercise once or twice a week
   2 Occasional exercise less than once a week
   7 Rarely exercise

9. Diabetes
   0 No personal or family history
   2 One parent with diabetes
   6 Two parents with diabetes
   9 Non–insulin-dependent diabetes
   13 Insulin-dependent diabetes

10. Body Mass Index (kg/m²)
    0 <23.0
    1 23.0–24.9
    2 25.0–28.9
    3 29.0–34.9
    5 35.0–39.9
    7 ≥ 40

11. Stress
    0 Relaxed most of the time
    1 Occasional stress and anger
    2 Frequently stressed and angry
    3 Usually stressed and angry

*Pack-years can be calculated by multiplying the number of packs you smoked per day by the number of years you smoked. For example, if you smoked a pack and a half a day for 5 years, you would have smoked the equivalent of $1.5 \times 5 = 7.5$ pack-years.
**INTERNET ACTIVITY**

Use the World Wide Web to learn more about one of the controllable risk factors for cardiovascular disease. Choose one of the risk factors from the quiz in this worksheet—preferably one for which you have a high score. Find out more about the risk factor by visiting one of the sites listed in your text or by doing a Web search.

Risk factor:  

Site(s) visited (URL):  

What did you learn about the risk factor? Did you identify any strategies you can apply to your daily life? Any changes you can make in your current behavior to control or lessen the risk factor? List at least three practical strategies for reducing your risk.
WELLNESS WORKSHEET 89

Facts About Cardiovascular Disease

Review your knowledge of CVD by filling in the blanks and answering the questions below. Refer to your textbook if necessary.

1. What are the six main risk factors for cardiovascular disease?
   a. ________________________________________
   b. ________________________________________
   c. ________________________________________
   d. ________________________________________
   e. ________________________________________
   f. ________________________________________

2. List four additional factors that may increase risk for cardiovascular disease.
   a. ________________________________________
   b. ________________________________________
   c. ________________________________________
   d. ________________________________________

3. Name the two main forms of cholesterol and describe their function.
   a. ____________________________________________________________________________________
   b. ____________________________________________________________________________________

4. Describe the difference between systolic and diastolic pressure. Give normal and high ranges for each.
   ____________________________________________________________________________________
   ____________________________________________________________________________________
   ____________________________________________________________________________________
   Why is hypertension dangerous? ________________________________________________________
   ____________________________________________________________________________________
   ____________________________________________________________________________________

List two treatments for hypertension.
   a. ____________________________________________________________________________________
   b. ____________________________________________________________________________________

5. What is atherosclerosis? How do plaques form, and why are they dangerous?
   ____________________________________________________________________________________
   ____________________________________________________________________________________
   ____________________________________________________________________________________
   ____________________________________________________________________________________
   ____________________________________________________________________________________

(over)
6. What is a heart attack? ___________________________________________________________________
__________________________________________________________________________________

What is angina pectoris? __________________________________________________________________
____________________________________________________________________________________

What is arrhythmia, and how does it relate to sudden cardiac death? ________________
____________________________________________________________________________________

What are three early signals of a heart attack?
  a. _______________________________________  c. _______________________________________
  b. _________________________________________

List and describe two procedures performed to treat heart disease.
  a. ____________________________________________________________________________________
  ____________________________________________________________________________________
  b. ____________________________________________________________________________________
  ____________________________________________________________________________________

7. List and describe the two major types of strokes.
  a. ____________________________________________________________________________________
  ____________________________________________________________________________________
  b. ____________________________________________________________________________________

List three warning signs of a stroke.
  a. _______________________________________  c. _______________________________________
  b. _______________________________________

8. List and describe three other types of heart disease.
  a. ____________________________________________________________________________________
  ____________________________________________________________________________________
  b. ____________________________________________________________________________________
  ____________________________________________________________________________________
  c. ____________________________________________________________________________________
WELLNESS WORKSHEET 90  
Hostility Quiz and Log

Current research indicates that there are three aspects of hostility that are particularly harmful to health: cynicism (a mistrusting attitude regarding other people’s motives), anger (an emotional response to other people’s “unacceptable” behavior), and aggression (behaviors in response to negative emotions such as anger and irritation). To get an idea of how hostile you are, check any of the following statements that are true for you.

_____ 1. I often get annoyed at checkout cashiers or the people in front of me when I’m waiting in line.
_____ 2. I usually keep an eye on the people I work or live with to make sure they do what they should.
_____ 3. I often wonder how homeless people can have so little respect for themselves.
_____ 4. I believe that most people will take advantage of you if you let them.
_____ 5. The habits of friends or family members often annoy me.
_____ 6. When I’m stuck in traffic, I often start breathing faster and my heart pounds.
_____ 7. When I’m annoyed with people, I really want to let them know it.
_____ 8. If someone does me wrong, I want to get even.
_____ 9. I’d like to have the last word in any argument.
_____ 10. At least once a week, I have the urge to yell at or even hit someone.

Five or more “true” statements suggest that you’re excessively hostile and should consider taking steps to mellow out.

If you are a hothead, try keeping a log of your hostile responses to people and situations (see over). Familiarize yourself with the patterns of thinking that lead to hostile feelings, and try to head them off before they develop into full-blown anger. If you feel your anger starting to build, ask yourself the following questions:

1. *Is this really important enough to get angry about?* For example, is having to wait an extra 5 minutes for a late bus so important that you should stew about it for the entire 15-minute ride?

2. *Am I really justified in getting angry?* Is the person in front of you really driving slowly, or are you trying to speed?

3. *Is getting angry going to make any real difference in this situation?* Will yelling and slamming the door really help your friend find the concert tickets he misplaced?

If you answer “yes” to all three questions, then you should calmly but assertively ask for what you want. A “no” to any question means that you should try to defuse your anger. Reason with yourself, distract your mind with another activity, or try one of the techniques for meditation or deep breathing described in Chapter 2 in your text. See Chapter 3 for additional anger management tips.
**Hostility Journal**

<table>
<thead>
<tr>
<th>Time</th>
<th>Location</th>
<th>What happened?</th>
<th>What were you thinking?</th>
<th>What were you feeling?</th>
<th>What did you do?</th>
</tr>
</thead>
</table>

**SOURCE:** Quiz from Williams, V., and R. Williams, 1999. *Life Skills*, New York: Times Books. Used with permission of the authors.
Review your knowledge of cancer by answering the questions below. Refer to your textbook if necessary.

1. What is cancer?

____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

2. List and describe the two general types of tumors.
   a. ____________________________________________________________________________________
   ____________________________________________________________________________________
   b. ____________________________________________________________________________________
   ____________________________________________________________________________________

3. What is metastasis?

____________________________________________________________________________________
____________________________________________________________________________________

What are the two ways metastasis can occur?
   a. ____________________________________________________________________________________
   b. ____________________________________________________________________________________

4. List and define four common classes of malignant tumors.
   a. ____________________________________________________________________________________
   ____________________________________________________________________________________
   b. ____________________________________________________________________________________
   ____________________________________________________________________________________
   c. ____________________________________________________________________________________
   ____________________________________________________________________________________
   d. ____________________________________________________________________________________
   ____________________________________________________________________________________

(over)
5. What is a mutagen? How can gene mutation cause cancer?
______________________________________________________________________________________
______________________________________________________________________________________
______________________________________________________________________________________
Give three examples of mutagens.
a. _______________________________________  c. _______________________________________
b. __________________________________________

6. What is a carcinogen?
______________________________________________________________________________________
______________________________________________________________________________________
______________________________________________________________________________________
Give three examples of carcinogens.
a. _______________________________________  c. _______________________________________
b. __________________________________________

7. Define the following, and describe how each can contribute to the development of cancer.
  oncogene: __________________________________________________________________________
  suppressor gene: _____________________________________________________________________
  cancer promoter: _____________________________________________________________________

8. List two dietary compounds that may contribute to cancer.
a. _______________________________________  b. _______________________________________
List six dietary compounds that may help prevent cancer.
a. _______________________________________  d. _______________________________________
b. _______________________________________  e. _______________________________________
c. _______________________________________  f. _______________________________________
WELLNESS WORKSHEET 92
Cancer Risk Factors and Prevention

Part I. General Risk Factor Checklist

Are you doing all you can to avoid cancer? You can directly influence some risk factors, such as diet and exposure to cigarette smoke, while others are beyond your control. The following statements relate to factors that can put you at increased risk for cancer. To identify your risk factors, check any statements that are true for you.

____ I have a family history of cancer. (Check any of the following family members who have had cancer; list the type(s) and the age of the individual at diagnosis.)
  ____ Mother ________________________________________________________________
  ____ Father _______________________________________________________________
  ____ Sister _________________________________________________________________
  ____ Brother ______________________________________________________________
  ____ Paternal grandfather ____________________________________________________
  ____ Paternal grandmother _________________________________________________
  ____ Maternal grandfather _________________________________________________
  ____ Maternal grandmother _________________________________________________

____ I use tobacco (any form).

____ I am constantly exposed to tobacco smoke at work or at home.

____ I live in a heavily polluted urban area.

____ I have frequently gotten blistering, peeling sunburns.

____ I am frequently exposed to sunlight and get a tan whenever possible.

____ I go to tanning salons or use a tanning lamp.

____ I have fair skin.

____ I have many moles.

____ I rarely use sunscreens.

____ I am overweight or obese.

____ I am sedentary.

____ I eat a diet that is rich in red meat and high in fat overall.

____ I eat a diet that is low in fiber overall.

____ I consume fewer than seven servings of fruits and vegetables per day.

____ I drink more than one (women) or two (men) alcoholic beverage(s) per day.

____ I have chronic hepatitis.

(over)
WELLNESS WORKSHEET 92 — continued

For Women Only (Check statements that are true for you; ignore those that are not applicable.)

____ I had early onset of menstruation.
____ My first pregnancy occurred after age 30.
____ I have HPV infection (genital warts).
____ I have genital herpes.

Part II. Assessing Your Risk for Specific Types of Cancer

Read the risk factors listed along the top of the chart. For any factor that applies to you, put a check in every unshaded box in its column. For the family history column, note any family member who has had the type of cancer listed at the left—record his or her relationship to you (uncle, brother, etc.) and age at diagnosis.

### Risk Factors

<table>
<thead>
<tr>
<th>Type of cancer</th>
<th>Smoking</th>
<th>Use of spit tobacco</th>
<th>Diet high in fat</th>
<th>Diet rich in meat</th>
<th>Diet low in fruits and vegetables</th>
<th>Little or no exercise</th>
<th>Obesity</th>
<th>Regular use of alcohol</th>
<th>Family history</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lung</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Colon and rectum</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Breast</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prostate</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stomach</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Esophagus</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kidney</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oral cavity</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Endometrium</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Larynx</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

To determine your risk for a particular type of cancer, examine the number of corresponding risk factors you’ve checked. Strong family history may also increase your risk—the more relatives who have had a particular type of cancer, the closer their relationship to you, and the younger their age at diagnosis, the greater your risk. Use this chart to identify lifestyle behaviors that you can change to lower your risk of cancer.

(over)

Part III. Regular Self-Monitoring and Screening Tests

In addition to the factors mentioned in Parts I and II of this worksheet, early diagnosis is important. Use the following table of recommended cancer screening tests to complete this portion of the worksheet.

### Screening Guidelines For the Early Detection of Cancer in Asymptomatic People

<table>
<thead>
<tr>
<th>Site</th>
<th>Recommendation</th>
</tr>
</thead>
</table>
| Breast     | • Yearly mammograms are recommended starting at age 40. The age at which screening should be stopped should be individualized by considering the potential risks and benefits of screening in the context of overall health status and longevity.  
  • Clinical breast exam should be part of a periodic health exam about every 3 years for women in their 20s and 30s and every year for women 40 and older.  
  • Women should know how their breasts normally feel and report any breast change promptly to their health care providers. Breast self-exam is an option for women starting in their 20s.  
  • Screening MRI is recommended for women with an approximately 20–25% or greater lifetime risk of breast cancer, including women with a strong family history of breast or ovarian cancer and women who were treated for Hodgkin’s disease. |
| Colon & rectum | Beginning at age 50, men and women should begin screening with 1 of the examination schedules below.  
  • A fecal occult blood test (FOBT) or fecal immunochemical test (FIT) every year  
  • A flexible sigmoidoscopy (FSIG) every 5 years  
  • Annual FOBT or FIT and flexible sigmoidoscopy every 5 years*  
  • A double-contrast barium enema every 5 years  
  • A colonoscopy every 10 years  
  * Combined testing is preferred over either annual FOBT or FIT, or FSIG every 5 years, alone. People who are at moderate or high risk for colorectal cancer should talk with a doctor about a different testing schedule. |
| Prostate   | The PSA test and the digital rectal examination should be offered annually, beginning at age 50, to men who have a life expectancy of at least 10 years. Men at high risk (African American men and men with a strong family history of 1 or more first-degree relatives diagnosed with prostate cancer at an early age) should begin testing at age 45. For men at both average risk and high risk, information should be provided about what is known and what is uncertain about the benefits and limitations of early detection and treatment of prostate cancer so that they can make an informed decision about testing. |
| Uterus     | Cervix: Screening should begin approximately 3 years after a woman begins having vaginal intercourse, but no later than 21 years of age. Screening should be done every year with regular Pap tests or every 2 years using liquid-based tests. At or after age 30, women who have had 3 normal test results in a row may get screened every 2 to 3 years. Alternatively, cervical cancer screening with HPV DNA testing and conventional or liquid-based cytology could be performed every 3 years. However, doctors may suggest a woman get screened more often if she has certain risk factors, such as HIV infection or a weak immune system. Women aged 70 and older who have had 3 or more consecutive normal Pap tests in the last 10 years may choose to stop cervical cancer screening. Screening after total hysterectomy (with removal of the cervix) is not necessary unless the surgery was done as a treatment for cervical cancer.  
  Endometrium: The American Cancer Society recommends that at the time of menopause all women should be informed about the risks and symptoms of endometrial cancer and strongly encouraged to report any unexpected bleeding or spotting to their physicians. Annual screening for endometrial cancer with endometrial biopsy beginning at age 35 should be offered to women with or at risk for hereditary nonpolyposis colon cancer (HNPCC). |
| Cancer-related checkup | For individuals undergoing periodic health examinations, a cancer-related checkup should include health counseling and, depending on a person's age and gender, might include examinations for cancers of the thyroid, oral cavity, skin, lymph nodes, testes, and ovaries, as well as for some non-malignant diseases. |

Additional Recommended Self-Exams

- All men and women should perform a monthly skin self-exam to look for early signs of skin cancer. A skin examination by a physician is recommended as part of a cancer-related checkup.
- Men who choose to perform a testicular self-exam should do so once a month.

Read through the table and identify the screening tests that are appropriate for you. List these below, and then compare the recommended frequency with your actual frequency.

<table>
<thead>
<tr>
<th>Test or procedure</th>
<th>Recommended frequency</th>
<th>Actual frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If your actual frequency is less than the recommended frequency, consider taking appropriate action. If necessary, make an appointment to see your physician or devise a behavior change plan for incorporating regular monthly self-exams for cancer into your routine; include strategies in your plan to help you remember to do your monthly self-exams and to keep yourself motivated.

**INTERNET ACTIVITY**

The World Wide Web has literally millions of sites that relate to cancer. Choose a particular type of cancer or a risk factor and use a search engine to find two helpful sites that provide information about it. You’ll have better luck if you choose a specific topic such as “cervical cancer and HPV,” “broccoli and cancer,” or “testicular self-exam” rather than a more general one—“breast cancer,” for example. Write a brief description of each site you locate.

- **Topic:** _______________________________________________________________________________
- **Site 1 (URL):** _________________________________________________________________________
  **Description:**
- **Site 2 (URL):** _________________________________________________________________________
  **Description:**
Diet and Cancer

Your diet may include both cancer fighters and cancer promoters. Track your diet for 3 days, putting a mark ("1" for day 1, "2" for day 2, "3" for day 3) next to any food on either of the following lists that you eat.

Potential Cancer Fighters

Orange and yellow vegetables and (some) fruits

_____ apricots
_____ cantaloupe
_____ carrots
_____ mangoes
_____ papaya
_____ pumpkin
_____ red and yellow peppers
_____ sweet potatoes (yams)
_____ winter squash (acorn, butternut, banana, etc.)

Dark-green leafy vegetables

_____ beet greens
_____ broccoli rabe
_____ chard
_____ collard greens
_____ dandelion greens
_____ kale
_____ mustard greens
_____ romaine and other dark lettuces
_____ spinach
_____ turnip greens

Cruciferous vegetables

_____ bok choy
_____ broccoli
_____ brussels sprouts
_____ cabbage
_____ cauliflower
_____ kohlrabi
_____ turnips

Citrus fruits

_____ grapefruit
_____ lemon
_____ lime
_____ orange
_____ tangerine

Whole grains

_____ whole-grain bread, cereal, and pasta; brown rice; etc.

Legumes

_____ peas, lentils, and beans, including fava, navy, kidney, pinto, black, and lima beans

Other healthful choices

_____ apples
_____ asparagus
_____ berries (strawberries, raspberries, blueberries)
_____ chili peppers
_____ grapes
_____ green peppers
_____ honeydew melon
_____ kiwi fruit
_____ onions, garlic, leeks
_____ radishes
_____ soy products (tofu, tempeh, soy milk, miso, soybeans, etc.)
_____ sprouts (alfalfa, broccoli)
_____ tomatoes
_____ watermelon

Potential Cancer Promoters

Foods high in fat and saturated fat

_____ fatty meats, poultry with skin
_____ deep-fried foods
_____ whole milk and full-fat dairy products
_____ alcoholic beverages
_____ salt-cured, smoked, and nitrite-cured foods
_____ meats grilled, barbecued, or fried at high temperatures

(Note: Research is ongoing, and these lists of cancer fighters and cancer promoters are not comprehensive. However, these lists can provide a basis for assessing and improving your diet. Remember, nearly all fruits, vegetables, and grains are healthy, disease-fighting dietary choices.)
Analyze Your Diet

Review the list of cancer fighters. Foods in the first six categories should be eaten daily or nearly daily; the remainder are all good choices. Count the total number of servings of cancer fighters you consumed and the number of servings of the first six groups of foods.

_____ Total servings

_____ Servings from first six groups (orange and yellow vegetables and fruits, dark-green leafy vegetables, cruciferous vegetables, citrus fruits, whole grains, and legumes)

Select five additional cancer fighters from the list to try over the next few days. Fill the names of these five foods into the table below, along with your plan for incorporating them into your diet (as a side dish, on a salad, as a substitute for another food, etc.).

Next, review the foods you checked on the list of cancer promoters. For each, identify a healthier alternative or substitute food that you could choose. Fill this information into the table below.

<table>
<thead>
<tr>
<th>Cancer Fighters to Try</th>
<th>Plan for Trying</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Cancer Promoters to Eliminate</th>
<th>Substitute Food/Alternative Choice</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Finally, put your plan for adding and substituting foods into action!

Part I. Skin Cancer Risk Assessment

Skin cancer is the most common cancer of all when cases of the highly curable forms are included in the count. Your risk of skin cancer from the ultraviolet radiation in sunlight depends on several factors. Take the quiz below to see how sensitive you are. The higher your UV-risk score, the greater your risk of skin cancer—and the greater your need to take precautions against too much sun.

Score 1 point for each true statement:

_____ 1. I have blond or red hair.  _____ 7. I have a family history of skin cancer.
_____ 2. I have light-colored eyes (blue, gray, green).  _____ 8. I work outdoors.
_____ 4. I have many moles.  _____ 10. I like to spend as much time in the sun as I can.
_____ 5. I had two or more blistering sunburns as a child.  _____ 11. I sometimes go to a tanning parlor or use a sunlamp.
_____ 6. I spent lots of time in a tropical climate as a child.

_____ Total score

Score  Risk of skin cancer from UV radiation
0  Low
1–3  Moderate
4–7  High
8–11  Very high

Part II. Skin Cancer Prevention

Fill in the details for a recent or typical day in which you were outdoors in the sun for a significant period of time. Compare your typical behavior with the recommendations for skin cancer prevention.

Time of day: _____________ Total duration of exposure: _____________

Recommendation: Avoid exposure between 10 a.m. and 4 p.m.

UV index for the day: ___________ (UV index ratings are usually available from the newspaper, the local weather bureau, or the NOAA Web site: http://www.epa.gov/sunwise/uvindex.html).

Recommendation: Take special care on days with a rating of 5 or more.

Clothing worn (describe):
_________________________________________________________________
_________________________________________________________________
_________________________________________________________________

Recommendation: Wear long-sleeved shirts made of tightly woven cotton fabric, a wide-brimmed hat, and sunglasses with UV protection, and use a lip balm with UV protection.
WELLNESS WORKSHEET 94 — continued

Sunscreen used? (Y/N) __________ Type and SPF rating: ________________________________  
*Recommendation: Use a broad-spectrum, water-resistant sunscreen with an SPF of 15 or higher. Look for sunscreens that contain ingredients that block both UVA and UVB rays.*

Sunscreen applied ________ minutes before sun exposure.  
*Recommendation: Apply 30–45 minutes prior to sun exposure.*

Amount of sunscreen applied: ________ ounces (Approximate by comparing the amount you applied with the amount in the full container.)  
*Recommendation: It takes about 1 ounce to cover an adult in a swimsuit. Many bottles or tubes of sunscreen contain a total of 4 ounces, so 1 ounce would be one-quarter of a typical bottle.*

How did your behavior compare with the recommendations? The next time you plan to spend a day outdoors, use this worksheet to help maximize your cancer prevention behavior.

**Part III. Skin Cancer Self-Exam**

The American Cancer Society (ACS) recommends taking 5 to 10 minutes for a skin self-exam at least once a month. The best time to do a self-exam is usually after a bath or shower. Use a full-length mirror and a handheld mirror so that you can check your entire body for moles, blemishes, and birthmarks. The ACS recommends the following “Down and Back” procedure. Check off each step as you perform a self-exam.

1. While standing, examine your face, chest, and arms (both sides of the arms) and belly.
2. Then, sit down to look at the front surfaces of your legs and feet. Use the mirror to examine the backs of your legs and check out the soles of your feet.
3. Stand up again and use the mirror to inspect your buttocks and upper back. Use the hand mirror to examine the back of your neck and your scalp. Part your hair or use a blow dryer to lift your hair and give you a close look at your scalp.

The ACS advises you to become familiar with birthmarks, moles, and blemishes so that you know what they look like and can identify any changes in them. Signs to look for are changes in size, texture, shape, and color of blemishes or a sore that does not heal.

**SOURCES:** American Cancer Society. 2009. *Skin Cancer Prevention and Early Detection: Examining Your Skin*  
(http://www.cancer.org/docroot/PED/content/ped_7_1_Skin_Cancer_Detection_What_You_Can_Do.asp#Examining_your_skin; retrieved March 9, 2009); The Skin Cancer Foundation. 2009. *Self-Examination: How to Spot Skin Cancer*  
(http://www.skincancer.org/Self-Examination.html; retrieved Mar. 9, 2009); American Academy of Dermatology. 2009.  
Performing an Oral Self-Exam

Performing regular oral self-exams may help spot early signs of oral cancer. Everyone should also have regular dental appointments that include an oral exam.

Who Is at Risk for Oral Cancer?

Key risk factors for oral cancer include tobacco use (any form, including cigarettes and spit tobacco), alcohol use, a past history and head and neck cancer, and exposure of the lips to the sun (without use of a lip balm containing sunscreen). The combination of tobacco use and alcohol use greatly increases the risk for oral cancer. Self-exams may be particularly important for people who use tobacco and/or alcohol.

Symptoms of Oral Cancer

The following are common symptoms of oral cancer:

- Patches inside your mouth or on your lips that are white, a mixture of red and white, or red
  - White patches (leukoplakia) are the most common. White patches sometimes become malignant.
  - Mixed red and white patches (erythroleukoplakia) are more likely than white patches to become malignant.
  - Red patches (erythroplakia) are brightly colored, smooth areas that often become malignant.
- A sore on your lip or in your mouth that won’t heal
- Any swelling, thickening, lump, bump, or rough or eroded area
- Bleeding in your mouth
- Loose teeth
- Difficulty or pain when swallowing; feeling that something is stuck in the back of the throat
- A change in your bite, or difficulty wearing dentures
- Numbness or tenderness in the mouth, neck, face
- A lump in your neck
- An earache

Self-Exam

Thoroughly examine your mouth for the symptoms of oral cancer listed above. Use a light to get a better view. If you are a spit tobacco user, pay special attention to the area where you typically hold tobacco in your mouth.

- Look at your lips from the outside and then pull each one out to examine the inside surfaces. Feel for any lumps or bumps.
- Pull out and back on each of your cheeks and look at the inside surfaces.
- With upper and lower teeth touching, check the gums bordering the outside surfaces of your teeth.
- Open wide and check the inside gum surfaces; use a mirror to view the roof of your mouth and the upper inside gum surfaces.
- Run your finger across your gum surfaces and the inside of your cheeks to check for any bumps or other abnormalities.
• Stick out your tongue and examine the top; move it from side to side and lift it up in order to view all the surfaces. Feel your tongue for lumps.
• Check your teeth for looseness.
• Finally, feel your neck for any lumps or swellings.
Report any changes to your dentist or physician promptly; she or he can do a professional examination to further evaluate any symptoms. Keep a record of your exams, both self and professional. Note any findings.

<table>
<thead>
<tr>
<th>Date of exam</th>
<th>Type (self or professional)</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Facts About Pathogens and How They Cause Disease

**Part I. Pathogens**

Familiarize yourself with different types of pathogens by completing the chart below. Refer to your textbook if necessary.

<table>
<thead>
<tr>
<th>Description and Examples</th>
<th>Diseases Caused</th>
<th>Possible Treatments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Bacteria</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Viruses</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Fungi</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Protozoa</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Parasitic worms</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Prions</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(over)
Part II. Chain of Infection

Fill in the steps in the chain of infection, and write a brief description of each step. List at least two ways that the chain can be broken at each step.

<table>
<thead>
<tr>
<th>Chain of Infection</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
WELLNESS WORKSHEET 97
Facts About the Body’s Defenses Against Infection

Review your knowledge of infection and immunity by answering the questions below. Refer to your textbook if necessary.

1. List and describe three of the body’s physical or chemical barriers against infection.
   a. ______________________________________________________________________
   b. ______________________________________________________________________
   c. ______________________________________________________________________

2. What general type of cells carry out the immune response? ______________________________________
   ______________________________________________________________________
   Where are these immune defenders produced? ____________________________________
   ______________________________________________________________________
   Describe each of the following types of cells and explain their role in the immune response.
   Neutrophils __________________________________________________________________
   ______________________________________________________________________
   Macrophages __________________________________________________________________
   ______________________________________________________________________
   Natural killer cells __________________________________________________________________
   ______________________________________________________________________
   Dendritic cells __________________________________________________________________
   ______________________________________________________________________
   Helper T cells __________________________________________________________________
   ______________________________________________________________________
   Killer T cells __________________________________________________________________
   ______________________________________________________________________
   Suppressor T cells __________________________________________________________________
   ______________________________________________________________________
   B cells ______________________________________________________________________
   ______________________________________________________________________
   Memory T and B cells __________________________________________________________________
   ______________________________________________________________________

3. What are antibodies? What is their role in the immune response?
   ______________________________________________________________________
   ______________________________________________________________________

(over)
4. How do the body’s defenders recognize an enemy? What is an antigen?
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

5. What is the inflammatory response?
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

6. Briefly describe the four phases of the immune response.
   a. ___________________________________________________________________________________
      ___________________________________________________________________________________
   b. ___________________________________________________________________________________
      ___________________________________________________________________________________
   c. ___________________________________________________________________________________
      ___________________________________________________________________________________
   d. ___________________________________________________________________________________
      ___________________________________________________________________________________

7. What is immunity? When and how does it occur?
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

8. When is an infected person contagious?
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

9. What is a vaccine?
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
What are the two types of immunity that a vaccine can confer?
   a. ___________________________________________________________________________________
   b. ___________________________________________________________________________________

10. What is an allergic reaction and how does it occur?
_____________________________________________________________________________________
The best thing you can do to prevent an infection is to limit your exposure to pathogens. The next best thing is to keep your immune system as strong as possible. Read through the following list of statements and check whether each is mostly true or mostly false for you.

**True    False**

**Exposure to Pathogens**

___ ___ I receive drinking water from a clean supply.

___ ___ The area in which I live has adequate sewage treatment.

___ ___ I frequently wash my hands with soap and warm water for at least 10–20 seconds.

___ ___ I avoid close contact with people who are infectious with diseases transmitted via the respiratory route (e.g., influenza, chicken pox, and tuberculosis).

___ ___ I do not inject drugs.

**When Outdoors**

___ ___ When hiking or camping, I do not drink water from streams, rivers, or lakes without first purifying it.

___ ___ I avoid contact with ticks, mosquitoes, rodents, bats, and other disease carriers.

___ ___ When hiking in the woods or playing in a yard in an area where Lyme disease or other tickborne infections have been reported, I take appropriate precautions:

___ Wear light-colored clothing: long pants, a long-sleeved shirt, and closed shoes.

___ Tuck my pants into my socks, shoes, or boots.

___ Tuck my shirt into my pants.

___ Wear light-colored, tightly woven fabrics.

___ Wear a hat.

___ Stay near the center of trails.

___ Check myself daily for ticks.

___ Shower and shampoo after each outing.

___ Wash clothes and check equipment after each outing.

___ Use an insect repellent containing DEET, picaridan, or oil of lemon eucalyptus on my skin and/or a spray containing permethrin on my clothing.

___ ___ If I discover a tick attached to my skin, I remove it immediately in an appropriate manner (fill in): ____________________________________________________________

_________________________________________________________________________

_________________________________________________________________________

_________________________________________________________________________

(over)
WELLNESS WORKSHEET 98 — continued

**True  False**

**In a Sexual Relationship**

____  ____ I am in a monogamous relationship with a mutually faithful, uninfected partner.
____  ____ I use condoms.
____  ____ I discuss STDs and prevention with new partners.
____  ____ I avoid engaging in high-risk behaviors with any person who might carry HIV.

**In the Kitchen**

____  ____ I wash my hands thoroughly with warm soapy water before and after handling food.
____  ____ I don’t let groceries sit in a warm car.
____  ____ I avoid buying food in containers that leak, bulge, or are severely dented.
____  ____ I use separate cutting boards for meat and for foods that will be eaten raw.
____  ____ I thoroughly clean all equipment (cutting boards, counters, utensils) before and after use.
____  ____ I rinse and scrub fresh fruits and vegetables carefully to remove all dirt.
____  ____ I cook all foods thoroughly, especially beef, poultry, fish, pork, and eggs.
____  ____ I verify that hamburgers are cooked to 160°F (71°C) with a food thermometer.
____  ____ I store foods below 40°F (5°C).
____  ____ I do not leave cooked or refrigerated foods at room temperature for more than 2 hours.
____  ____ I thaw foods in the refrigerator or microwave.
____  ____ I use only pasteurized milk and juice.
____  ____ I avoid coughing or sneezing over foods, even when I’m healthy.
____  ____ I cover any cuts on my hands when handling food.

**To Keep Your Immune System Healthy**

____  ____ I eat a balanced diet, following the guidelines presented in the Dietary Guidelines for Americans.
____  ____ I maintain a healthy weight.
____  ____ I get enough sleep, 6–8 hours per night.
____  ____ I exercise regularly.
____  ____ I don’t smoke, and I drink alcohol only in moderation.
____  ____ I wash my hands frequently.
____  ____ I have effective ways of coping with stress.
____  ____ I get all recommended immunizations and booster shots.

For people with heart valve disorders that place them at increased risk of infection: I check with my health care provider about antibiotic use before dental or surgical procedures and before body piercing.

False answers indicate areas where you could change your behavior to help avoid infectious diseases. Consider creating a behavior change strategy for any statement you checked as false.

WELLNESS WORKSHEET 99

Personal Infectious Disease Record

Place a check next to any of the following infectious diseases you have had. Where appropriate, list your age at the time of the infection and any special circumstances surrounding the time of the infection (e.g., your entire first grade class got the chicken pox; you got mononucleosis at a time of high stress) in the box provided. Circle any disease for which you have been vaccinated.

_____ Athlete’s foot  _____ Lyme disease  _____ Scarlet fever
_____ Chicken pox  _____ Malaria  _____ Shingles
_____ Chlamydia  _____ Measles  _____ Strep throat
_____ Cold sores (HSV)  _____ Meningitis  _____ Syphilis
_____ Diphtheria  _____ Mononucleosis  _____ Tetanus
_____ Encephalitis  _____ Mumps  _____ Toxic shock syndrome
_____ Genital herpes (HSV)  _____ Whooping cough (pertussis)  _____ Trichomoniasis
_____ Genital warts (HPV)  _____ Pinworm  _____ Tuberculosis
_____ Giardiasis  _____ Pneumonia  _____ Ulcer (H. pylori)
_____ Gonorrhea  _____ Poliomyelitis  _____ Urinary tract infection
_____ Hepatitis A  _____ Pubic lice  _____ Warts (site: ________)
_____ Hepatitis B  _____ Rabies  _____ Yeast infection
_____ Hepatitis C  _____ Rheumatic fever  _____ Other: _____________
_____ HIV infection  _____ Ringworm  _____ Other: _____________
_____ Influenza  _____ Rubella (German measles)  _____ Other: _____________
_____ Jock itch  _____ Scabies  _____ Other: _____________

<table>
<thead>
<tr>
<th>Disease</th>
<th>Age</th>
<th>Circumstances</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(over)
**INTERNET ACTIVITY**

Choose one of the emerging infectious diseases described in the chapter or one you’ve heard about recently in the news. Use the sites below or perform a search to learn more about the disease. What causes the disease, and what are its effects? How is it transmitted? Where is it most common? What are some of the reasons for its emergence and/or spread? What can public health officials and individuals do to reduce the spread of the disease?

- CDC National Center for Preparedness, Detection, and Control of Infectious Diseases: http://www.cdc.gov/ncpdcid
- National Institute of Allergy and Infectious Diseases: http://www.niaid.nih.gov
- World Health Organization: http://www.who.int/health_topics/en

Disease: ____________________________________________________________________________

Site(s) visited (URL): ___________________________________________________________________

Information obtained:
WELLNESS WORKSHEET 100

Allergy Record

Allergic disorders are very common among people of all ages. Put a check next to any of the following allergic disorders that you have experienced:

- Allergic rhinitis (persistent nasal congestion, runny nose, and/or postnasal drip)
- Atopic dermatitis (chronic or recurrent inflammation of the skin)
- Allergic conjunctivitis (red, itchy, watery eyes)
- Asthma
- Sinusitis (chronic sinus infection characterized by persistent cold symptoms, often including facial pain)
- Contact dermatitis (rash resulting from contact with an allergen)
- Food allergy
- Insect sting allergy
- Drug allergy

Next, create a record of your allergy triggers. Put a check next to any substance to which you have had an allergic reaction; if appropriate, list the specific type of substance you are allergic to (cats, spider bites, nuts, and so on). Describe the type of reaction you had.

<table>
<thead>
<tr>
<th>✔ Allergen</th>
<th>Specific Type(s)</th>
<th>Reaction(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poison ivy or oak</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Animals</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Feathers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Insect bites or stings</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Molds</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dust mites</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ragweed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pollen</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Foods</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(over)
INTERNET ACTIVITY
Many people suffer from seasonal allergies, in which the severity of symptoms varies with the concentration of environmental allergens such as pollen. Current pollen counts and yearly pollen patterns are available from the Web site of the American Academy of Allergy, Asthma, and Immunology’s National Allergy Bureau (http://www.aaaai.org/nab). Visit the site and locate the pollen information for the city closest to you. Check both today’s pollen count and the record over time for the area. Which types of pollen are at the highest concentrations in which months? If you have allergies, can you see a relationship between your pattern of symptoms and the seasonal pattern of pollen concentrations in your area?

City: _________________________________________________________________________________

Current pollen counts: ___________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

Seasonal pattern (describe):
Familiarize yourself with different types of sexually transmitted diseases by completing the chart below.

<table>
<thead>
<tr>
<th></th>
<th>Early symptoms</th>
<th>Potential long-term effects</th>
<th>Diagnosis and treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV infection</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chlamydia</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gonorrhea</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pelvic inflammatory</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>disease</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Genital warts (HPV</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>infection)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### WELLNESS WORKSHEET 101 — continued

<table>
<thead>
<tr>
<th></th>
<th>Early symptoms</th>
<th>Potential long-term effects</th>
<th>Diagnosis and treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Genital herpes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis B</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Syphilis</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### INTERNET ACTIVITY

Visit several of the sites listed in the For More Information section of Chapter 18 in your text (Chapter 13 in the brief version)—or do a Web search—to complete one of the following activities.

1. Find information on STD prevention and safer sex. Look for strategies for talking with a sex partner, saying no to sex or drugs, or using a condom correctly.

2. Find information about a recent development or advance in HIV incidence, treatment, prevention, or testing. Look for a site with news posted within the past month.

Site visited (URL): ________________________________________________________________

Information available from site:
Do Your Attitudes and Behaviors Put You at Risk for STDs?

Part I. Risk Assessment

All sexually transmitted diseases are preventable. You have control over the behaviors and attitudes that place you at risk for contracting STDs and for increasing their negative effects on your health. To identify your risk factors for STDs, read the following list of statements and identify whether they’re true or false for you.

Note: The statements in this assessment assume current sexual activity. If you have never been sexually active, you are not now at risk for STDs. Respond to the statements in the quiz based on how you realistically believe you would act. If you are currently in a mutually monogamous relationship with an uninfected partner or are not currently sexually active (but have been in the past), you are at low risk for STDs at this time. Respond to the statements in the quiz according to your attitudes and past behaviors.

True  False

_____ _____ 1. I have only one sex partner.
_____ _____ 2. I always use a latex condom for each act of intercourse, even if I am fairly certain my partner has no infections.
_____ _____ 3. I do not use oil-based lubricants or other oil-based products with condoms.
_____ _____ 4. I discuss STDs and prevention with new partners before having sex.
_____ _____ 5. I do not use alcohol or another mood-altering drug in sexual situations.
_____ _____ 6. I would tell my partner if I thought I had been exposed to an STD.
_____ _____ 7. I am familiar with the signs and symptoms of STDs.
_____ _____ 8. I regularly perform genital self-examination to check for signs and symptoms of STDs.
_____ _____ 9. When I notice any sign or symptom of any STD, I consult my physician immediately.
_____ _____ 10. I obtain screening for HIV and other STDs regularly. In addition (if female), I obtain yearly pelvic exams and Pap tests.
_____ _____ 11. When diagnosed with an STD, I inform all recent partners.
_____ _____ 12. When I have a sign or symptom of an STD that goes away on its own, I still consult my physician.
_____ _____ 13. I do not use drugs prescribed for friends or partners or left over from other illnesses to treat STDs.
_____ _____ 14. I do not share syringes or needles to inject drugs.

False answers indicate attitudes and behaviors that may put you at risk for contracting STDs or for suffering serious medical consequences from them. For more on your risk factors for STDs, take the online assessment available at http://www.thebody.com/surveys/sexsurvey.html.
Part II. Communication

1. List three ways to bring up the subject of STDs with a new partner. How would you ask whether he or she has been exposed to any STDs or engaged in any risky behaviors? (Remember that because many STDs can be asymptomatic, it is important to know about past behaviors even if no STD was diagnosed.)
   
   a. ____________________________________________________________________________________
      ____________________________________________________________________________________
   
   b. ____________________________________________________________________________________
      ____________________________________________________________________________________
   
   c. ____________________________________________________________________________________
      ____________________________________________________________________________________

2. List three ways to bring up the subject of condom use with your partner. How might you convince someone who does not want to use a condom?
   
   a. ____________________________________________________________________________________
      ____________________________________________________________________________________
   
   b. ____________________________________________________________________________________
      ____________________________________________________________________________________
   
   c. ____________________________________________________________________________________
      ____________________________________________________________________________________

3. If you had an STD in the past that you might possibly still pass on (e.g., herpes), how would you tell your partner(s)?
   
   ____________________________________________________________________________________
   ____________________________________________________________________________________
   ____________________________________________________________________________________

4. If you were diagnosed with an STD that you believe was given to you by your current partner, how would you begin a discussion of STDs with him or her?
   
   ____________________________________________________________________________________
   ____________________________________________________________________________________
   ____________________________________________________________________________________

Talking about STDs may be a bit awkward, but the temporary embarrassment of asking intimate questions is a small price to pay to avoid contracting or spreading disease.
WELLNESS WORKSHEET 103

Facts About Environmental Health

Review your knowledge of important issues in environmental health by answering the questions below. Refer to your textbook if necessary.

1. List two current problems regarding clean water and a possible solution for each.
   a. ____________________________________________________________________________________
   ____________________________________________________________________________________
   b. ____________________________________________________________________________________
   ____________________________________________________________________________________

2. What are the major components of household trash? What are some of the problems with trash disposal?
   ____________________________________________________________________________________
   ____________________________________________________________________________________
   ____________________________________________________________________________________
   ____________________________________________________________________________________
   ____________________________________________________________________________________
   ____________________________________________________________________________________

3. List three factors that contribute to population growth and three factors that may limit it.
   a. ________________________________________ d. _______________________________________
   b. ________________________________________ e. _______________________________________
   c. ________________________________________ f. _______________________________________

4. What is a temperature inversion, and why is it dangerous?
   ____________________________________________________________________________________
   ____________________________________________________________________________________
   ____________________________________________________________________________________
   ____________________________________________________________________________________
   ____________________________________________________________________________________

5. What is the greenhouse effect?
   ____________________________________________________________________________________
   ____________________________________________________________________________________
   ____________________________________________________________________________________
   ____________________________________________________________________________________
   ____________________________________________________________________________________

6. What is the ozone layer, and why is it important to human health?
   ____________________________________________________________________________________
   ____________________________________________________________________________________
   ____________________________________________________________________________________
   ____________________________________________________________________________________
   ____________________________________________________________________________________
How and where does thinning of the ozone layer occur?
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

7. How fast is the world’s population growing?
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

8. List and describe two current chemical pollution problems. What are the effects of each chemical? How do people come in contact with them?
a. ___________________________________________________________________________________
   ___________________________________________________________________________________
   ___________________________________________________________________________________
b. ___________________________________________________________________________________
   ___________________________________________________________________________________
   ___________________________________________________________________________________

9. What negative effects can occur when an individual is exposed to loud and persistent noise?
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

10. What is biodiversity, and why is it important?
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
Environmental Health Checklist

The following list of statements relates to your impact on the environment. Put a check next to the statements that are true for you.

**Conserving Energy and Improving the Air**
- I ride my bike, walk, use public transportation, or carpool in a fuel-efficient vehicle whenever possible.
- I keep my car tuned up and well maintained.
- My vehicle is fuel efficient (city: ____ MPG; highway: ____ MPG).
- My car tires are inflated at the proper pressure.
- I avoid quick starts and drive within the speed limit.
- I don’t use my car’s air conditioner when opening the window would suffice.
- My residence is well insulated.
- Where possible, I use compact fluorescent bulbs instead of incandescent bulbs.
- I turn off lights and appliances when they are not in use.
- I avoid turning on heat or air conditioning whenever possible.
- I run the washing machine, dryer, and dishwasher only when they have full loads.
- I dry my hair with a towel rather than a hair dryer.
- I keep my car’s air conditioner in good working order and have it serviced by a service station that recycles CFCs.
- I have an energy-efficient refrigerator, which I keep in good working order.

**Reducing Garbage**
- When shopping, I choose products with the least amount of packaging.
- I choose recycled and recyclable products and those sold in bulk.
- I avoid products packaged in plastic and unrecycled aluminum.
- I store food in glass jars and reusable plastic containers rather than using plastic wrap.
- I take my own bag along when I go shopping.
- Whenever possible, I use long-lasting or reusable products (such as refillable pens and rechargeable batteries).
- I use a ceramic mug and metal spoon for coffee and tea rather than disposable cups and stirrers.
- I recycle newspapers, glass, cans, paper, and other materials.
- I have a compost pile or bin for my organic garbage or I take my organic garbage to a community composting center.

**Reducing Chemical Pollution and Toxic Wastes**
- When shopping, I read labels and try to buy the least toxic products available.
- I don’t pour toxic materials (bleach, motor oil, etc.) down the sink.
____ If I am unsure of the proper way to dispose of something, I contact my local health department or environmental health office.
____ Whenever possible, I buy organic produce or produce that is in season and has been grown locally.

**Saving Water**
____ I take showers instead of baths.
____ I take short showers and switch off the water when I’m not actively using it.
____ I do not run the water while brushing my teeth, shaving, or hand-washing clothes or dishes.
____ My sinks have aerators installed in them.
____ My shower has a low-flow showerhead.
____ I have a water-saving toilet, or I have a water-displacement device in my toilet.
____ I fix any faucets that leak.

**Preserving Wildlife and the Natural Environment**
____ I snip or rip plastic six-pack rings before discarding them.
____ I don’t buy products made from endangered species.
____ When hiking or camping, I never leave anything behind.

Statements that you have not checked can help you identify behaviors that you can change to improve environmental health. Consider planning a behavior change activity to alter one or more of your behaviors. To change some of the items listed, you may need the cooperation of your family and/or roommate(s). If there are environmental issues that are important to you, you can go beyond individual action by informing others, joining and volunteering your time to organizations working on environmental problems, and contacting your elected representatives.

**INTERNET ACTIVITY**
Writing letters to elected officials is one way you can become more involved in promoting environmental health. Choose one of your representatives—local, state, or United States Congress—and locate her or his e-mail address. To locate contact information, visit one of the following sites or do a Web search: U.S. Senate (http://www.senate.gov); U.S. House of Representatives (http://www.house.gov/writerep). Fill in the e-mail address of your representative, and briefly describe how you located it.

Name: ________________________________________________________________________________
Position: _____________________________________________________________________________
E-mail address: _______________________________________________________________________
How located:
**WELLNESS WORKSHEET 105**  
Recycling and Shopping Planner

**Part I. Recyclables Reminder**

Research the recycling facilities in your area. For each type of recyclable, fill in where it can be recycled and what preparation is required (for example, removing labels or tying bundles).

**ALUMINUM AND STEEL CANS**

<table>
<thead>
<tr>
<th>Type</th>
<th>Can be recycled at (location):</th>
</tr>
</thead>
<tbody>
<tr>
<td>---</td>
<td>Aluminum cans</td>
</tr>
<tr>
<td>---</td>
<td>Foil OK?</td>
</tr>
<tr>
<td>---</td>
<td>Pie plates, frozen food trays, etc. OK?</td>
</tr>
<tr>
<td>---</td>
<td>Steel cans</td>
</tr>
</tbody>
</table>

Preparation: ____________________________________________________________

**GLASS**

<table>
<thead>
<tr>
<th>Type</th>
<th>Can be recycled at (location):</th>
</tr>
</thead>
<tbody>
<tr>
<td>---</td>
<td>Clear glass</td>
</tr>
<tr>
<td>---</td>
<td>Green glass</td>
</tr>
<tr>
<td>---</td>
<td>Amber glass</td>
</tr>
</tbody>
</table>

Preparation: ____________________________________________________________

**PAPER**

<table>
<thead>
<tr>
<th>Type</th>
<th>Can be recycled at (location):</th>
</tr>
</thead>
<tbody>
<tr>
<td>---</td>
<td>Newspaper</td>
</tr>
<tr>
<td>---</td>
<td>Corrugated cardboard</td>
</tr>
<tr>
<td>---</td>
<td>Brown paper bags OK?</td>
</tr>
<tr>
<td>---</td>
<td>Office paper</td>
</tr>
<tr>
<td>---</td>
<td>Laser-printed paper OK?</td>
</tr>
<tr>
<td>---</td>
<td>Mixed papers</td>
</tr>
<tr>
<td>---</td>
<td>Acceptable papers are:</td>
</tr>
<tr>
<td>---</td>
<td>Glossy paper</td>
</tr>
<tr>
<td>---</td>
<td>Glued bindings OK?</td>
</tr>
</tbody>
</table>

Preparation: ____________________________________________________________

**PLASTIC**

<table>
<thead>
<tr>
<th>Type</th>
<th>Can be recycled at (location):</th>
</tr>
</thead>
<tbody>
<tr>
<td>---</td>
<td>1 PET or PETE</td>
</tr>
<tr>
<td>---</td>
<td>2 HDPE</td>
</tr>
<tr>
<td>---</td>
<td>Others?</td>
</tr>
</tbody>
</table>

(over)
OTHER

<table>
<thead>
<tr>
<th>Type</th>
<th>Can be recycled at (location):</th>
</tr>
</thead>
<tbody>
<tr>
<td>Batteries (home)</td>
<td></td>
</tr>
<tr>
<td>Batteries (car)</td>
<td></td>
</tr>
<tr>
<td>Motor oil</td>
<td></td>
</tr>
<tr>
<td>Paint</td>
<td></td>
</tr>
</tbody>
</table>

Preparation: ________________________________________________________________

Part II. Critical Shopping for Environmental Health

You can promote environmental health by purchasing sustainable products whenever possible. A product is sustainable if it is made, used, and disposed of in such a way that it could continue to be made, used, and disposed of again and again. To begin building your environmental shopping skills, choose a product and ask yourself the following questions about it.

Product: ________________________________________________________________

1. Do I really need this product? Why? (Every product you don’t buy saves resources and eliminates waste.)

2. Is the product safe to use? (Choose nontoxic alternatives whenever possible.)

3. Is the product practical, durable, well made, of good quality, with a timeless design? Will I be able to keep it for a long time before replacing it? (Products that last are better for the environment.)

4. Is the product made from renewable or recycled materials?

5. How will I dispose of the product, and what environmental impact will that disposal have?

6. What kind of package does the product have?

7. How far has the product been shipped to reach the retail outlet? (Products produced locally use fewer resources and produce less pollution during transport.)

8. Is the product a good value for the money? Is the environmental health benefit the product provides worth the extra cost?
WELLNESS WORKSHEET 106
Choosing a Primary Care Physician

To help evaluate your current physician or choose a new one, fill in the requested information and complete the checklist.

General Information
Physician name: __________________________ Training/certification: __________________________
Office location: __________________________ Hospital privileges: __________________________
Office phone: __________________________ Office hours: ________________________________

Does the physician take my current insurance? ______ Is she or he accepting new patients? _____
Is advice available by phone? If so, at what number and at what times? _______________________________
Is advice available by e-mail? If so, at what e-mail address? _______________________________________
Who covers for the physician when she or he is unavailable? _______________________________________ 
What should I do if I need care urgently? _______________________________________________________

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td></td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td></td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td></td>
<td>9</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td></td>
<td>11</td>
<td>12</td>
</tr>
<tr>
<td></td>
<td></td>
<td>13</td>
<td>14</td>
</tr>
<tr>
<td></td>
<td></td>
<td>15</td>
<td>16</td>
</tr>
</tbody>
</table>

“No” answers may indicate areas where your relationship with a physician or the running of the office may be less than ideal. Discuss any areas of concern with your physician. If things do not improve, consider changing physicians. Remember, your physician works for you.
INTERNET ACTIVITY
Information about many U.S. physicians and hospitals is available online. Choose a local physician or hospital, and see what information you can find from the following sites. Alternatively, search for a physician with a particular type of specialty practicing in your area.

- American Medical Association (Doctor Finder): http://www.ama-assn.org
- American Board of Medical Specialties: http://www.abms.org
- Health Grades: http://www.healthgrades.com
- Joint Commission: http://www.jointcommission.org
- Public Citizen: http://www.citizen.org/hrg

Site(s) visited (URL): ________________________________________________________________
Name of physician or hospital: ________________________________________________________
Information obtained:

Next, search for a local clinic, hospital, or physician’s office. Do any of the medical facilities in your area sponsor their own Web site? If so, describe the information available at the site.

Clinic, hospital, or medical office: _______________________________________________________
Site visited (URL): _____________________________________________________________________
Information available:
One of the most controversial and fastest growing areas of health care is the use of complementary and alternative therapies such as acupuncture, massage therapy, and dietary supplements. Because there is less information about CAM therapies and less regulation of the associated products and providers, it is important for consumers who choose to use CAM to take an active role in their health care, to use their critical thinking skills, and to be cautious. In addition, the lack of information means that any treatment decisions are likely to be a matter of individual judgment. However, there are steps consumers can take to help increase their safety.

**Working with Your Physician**

The NIH National Center for Complementary and Alternative Medicine (NCCAM) cautions consumers not to seek CAM therapies without first consulting a licensed health care provider. Check off the following steps as you complete them.

- Visit a physician for an evaluation and diagnosis of your symptoms.
- Discuss and try conventional treatments that have been shown to be beneficial for your condition.
- Inform your physician of any CAM therapies you are trying or thinking of trying. This is critically important because a CAM therapy may interact dangerously with a conventional treatment that you are receiving.
- Ask your physician if she or he has any concerns about any CAM treatment you are considering, particularly in the following areas:
  - **Safety.** Is there something unsafe about the treatment in general or specifically for you? Is there anything she or he is aware of that could increase the safety of the therapy?
  - **Effectiveness.** Is she or he aware of any research about the use of the therapy for your condition?
  - **Timing.** Is the immediate use of a conventional treatment indicated?
  - **Cost.** Does she or he think the therapy is likely to be very expensive, especially in light of the potential benefit?
- If you plan to pursue a CAM therapy against your physician’s advice, tell her or him.
- If appropriate, schedule a follow-up visit with your physician to assess your condition and your progress after a certain amount of time using a CAM therapy.
- Keep a symptom diary to more accurately track your symptoms and gauge your progress. (Symptoms such as pain and fatigue are very difficult to recall with accuracy, so an ongoing symptom diary is an important tool.)

**Investigating CAM Therapies and Practitioners**

- To the best of your ability, determine whether any research has been conducted on the CAM therapy you are considering. What studies have been done to test its safety? Its effectiveness for your condition? Use the Internet to search for information. One database, called CAM on PubMed, has been developed by the National Library of Medicine and the NCCAM; it provides citations and abstracts of peer-reviewed scientific studies on CAM therapies. If you don’t have access to the Internet, contact the NCCAM Clearinghouse (1-888-644-6226), visit your local library, or ask your physician about resources.

(over)
___ If possible, talk to people with the same condition you have who have received the same treatment. (Remember, however, that patient testimonials should not be used as the sole criterion for choosing a therapy or assessing its safety and efficacy. Controlled scientific trials usually provide the best information and should be consulted whenever possible. The absence of documented dangers is not the same thing as proof of safety.)

___ Review the CAM practitioner’s credentials. Ask about education, training, licensing, and certification. Examine the condition of the office or clinic. Does it seem well organized and well run?

___ If appropriate, check with the appropriate state or local regulatory agency or consumer affairs department to determine if any complaints have been lodged against the practitioner.

___ Ask the practitioner why she or he thinks the treatment will be beneficial for your condition. Ask her or him to fully describe what the treatment consists of and any potential problems.

___ Fully describe any conventional treatments you are currently undergoing.

___ Find out about the expected duration of treatment.

___ Find out about the expected cost of the treatment. Does it seem reasonable? Will your health insurance pay some or all of the costs?

If anything a CAM practitioner says or recommends directly conflicts with advice from your physician, you should discuss it with your physician before making any major changes in any current treatment regimen or in your lifestyle. Additional consumer-oriented advice about CAM therapies can be found in your text in the sections on dietary supplements, cancer quackery, and general health fraud.

**INTERNET ACTIVITY**

Choose one CAM therapy to investigate. Use the resources listed below or do a search to locate at least one research study on the therapy you’ve chosen to investigate. Once you find a study, look closely at it. How big was the study? Who were the participants? What was the purpose of the study? What did the study find? Can you determine if it had any of the characteristics of a well-designed study described in Chapter 20 (Chapter 15 in the brief version): placebo-controlled, randomized, and double-blind? Was it published in a peer-reviewed medical journal?


Site visited (URL): _____________________________________________________________________

Therapy: _____________________________________________________________________________

Citation of study: _____________________________________________________________________

_____________________________________________________________________________________

Description of study:

Finally, search the Web site of the FDA (http://www.fda.gov) or the Federal Trade Commission (FTC; http://www.ftc.gov) for the therapy you investigated to see if there are any consumer warnings about particular treatments, products, or devices. Describe what you find:

WELLNESS WORKSHEET 108

Your Personal Health Profile

Complete as much as possible of this personal health profile and keep it with Wellness Worksheets 99 and 100 (Personal Infectious Disease Record and Allergy Record) so that you have a complete record of your health status. Keep your profile up to date.

General Information

Age: __________  Blood lipid levels:
Height: __________  Total cholesterol: __________
Weight: __________  HDL: __________
Are you currently trying to _____ gain or LDL: __________
_____ lose weight? (check if appropriate) Triglycerides: __________
Blood pressure: _____ / _____  Blood glucose level: __________

Medical Conditions

Check any of the following that apply to you and add other conditions that might affect your health and well-being.

____ heart disease  ____ back pain  ____ depression, anxiety, or
____ lung disease  ____ arthritis  another psychological disorder
____ diabetes  ____ other injury or joint  ____ eating disorder
____ allergies  ____ other problem  ____ other: _____________________
____ asthma  ____ substance abuse problem  ____ other: _____________________

List any conditions or diseases that are common in your family and/or ethnic group (see Wellness Worksheets 8 and 45).

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Medications/Treatments

List any medications or supplements you are taking or any medical treatments you are undergoing. Include the name of the substance or treatment and its purpose. Include both prescription and over-the-counter drugs and any vitamin, mineral, or other dietary supplement you are taking.

Medication/treatment  Condition/purpose
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
Screening Tests and Vaccinations

To ensure that you are getting the most out of your medical care, keep a record of your screening tests and vaccinations; see Chapters 15–17 (Chapters 12–13 in the brief version) for more information on these. Fill in any additional tests and vaccinations that are appropriate for your age, gender, and medical history.

<table>
<thead>
<tr>
<th>Screening test/immunization</th>
<th>Date last performed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood pressure check</td>
<td></td>
</tr>
<tr>
<td>Cholesterol measurement</td>
<td></td>
</tr>
<tr>
<td>Vision test</td>
<td></td>
</tr>
<tr>
<td>Dental exam</td>
<td></td>
</tr>
<tr>
<td>STD screening, including HIV test</td>
<td></td>
</tr>
<tr>
<td>Pelvic exam and Pap test (women only)</td>
<td></td>
</tr>
<tr>
<td>Clinical breast exam (women only)</td>
<td></td>
</tr>
<tr>
<td>Other cancer screening tests, as appropriate</td>
<td></td>
</tr>
<tr>
<td>Tetanus/diphtheria/pertussis vaccination</td>
<td></td>
</tr>
<tr>
<td>Influenza vaccination</td>
<td></td>
</tr>
<tr>
<td>Hepatitis B vaccination</td>
<td></td>
</tr>
<tr>
<td>HPV vaccination (women only)</td>
<td></td>
</tr>
<tr>
<td>Meningococcal disease vaccination</td>
<td></td>
</tr>
<tr>
<td>other:</td>
<td></td>
</tr>
<tr>
<td>other:</td>
<td></td>
</tr>
</tbody>
</table>

Health Care Providers

Primary care physician: name ________________________ phone _______________

Specialist physician: name ________________________ phone _______________

Condition treated: _________________________________________________________

Other health care provider: name ________________________ phone _______________

Condition treated: _________________________________________________________

Pharmacy: name ________________________ phone _______________

Dentist: name ________________________ phone _______________

Optometrist/ophthalmologist: name ________________________ phone _______________

Health insurance provider: name ________________________ phone _______________

Policy number: _________________________________________________________

Dental insurance provider: name ________________________ phone _______________

Policy number: _________________________________________________________

Vision care insurance provider: name ________________________ phone _______________

Policy number: _________________________________________________________
**WELLNESS WORKSHEET 109**

**Safe Use and Storage of Medications**

---

**Medication Checkup**

To help determine if you know all you need to in order to use your medications safely, complete as much of the following information as possible for the most recent over-the-counter or prescription medication that you have used. Consult the label or package inserts if needed.

<table>
<thead>
<tr>
<th>Name/brand:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Use (condition or symptom):</td>
<td></td>
</tr>
<tr>
<td>Directions for use: dose (amount), frequency, timing (with meals?), in cases of a missed dose:</td>
<td></td>
</tr>
<tr>
<td>Total period of time for use:</td>
<td></td>
</tr>
<tr>
<td>How soon to expect improvement, and action to take if no improvement occurs:</td>
<td></td>
</tr>
<tr>
<td>Warnings/contraindications for use:</td>
<td></td>
</tr>
<tr>
<td>Possible side effects and what to do:</td>
<td></td>
</tr>
<tr>
<td>Serious reactions to watch for and report:</td>
<td></td>
</tr>
<tr>
<td>Activities or substances to avoid:</td>
<td></td>
</tr>
<tr>
<td>Instructions in case of overdose:</td>
<td></td>
</tr>
<tr>
<td>Storage and other information:</td>
<td></td>
</tr>
<tr>
<td>Number of refills:</td>
<td></td>
</tr>
<tr>
<td>Expiration date:</td>
<td></td>
</tr>
<tr>
<td>Other medications or supplements in use:</td>
<td></td>
</tr>
<tr>
<td>Safety of use of this combination checked with physician or pharmacist?</td>
<td></td>
</tr>
</tbody>
</table>

Note: For both OTC and prescription medications, it’s important to check with a physician or pharmacist about the safety of using any medications in combination with each other or with dietary supplements.

**Your Home Medical Care Kit**

Most medications should be stored in a cool, dark, and dry place, preferably in a locked container and out of a child’s reach (such as the top of a linen closet). If exposed to the heat and humidity of a bathroom, many drugs deteriorate rapidly. Use your bathroom medicine cabinet for supplies that aren’t affected by heat and humidity. Evaluate your home medical care kit using the following checklist. Before checking off any item, however, make sure that its expiration date hasn’t passed. Throw out expired items and consider purchasing any supplies that you don’t check off. Add any items that are appropriate for you: for example, if you sometimes have exercise-related injuries, you might want to keep an ice pack, heating pad, and elastic bandage on hand; if you have allergies, you might add a decongestant to the list.
WELLNESS WORKSHEET 109 — continued

<table>
<thead>
<tr>
<th>Closet</th>
<th>Medicine cabinet</th>
</tr>
</thead>
<tbody>
<tr>
<td>____ Analgesic (relieves pain)</td>
<td>____ Adhesive bandages</td>
</tr>
<tr>
<td>____ Antacid (relieves upset stomach)</td>
<td>____ Adhesive tape</td>
</tr>
<tr>
<td>____ Antibiotic ointment (reduces risk of infection)</td>
<td>____ Alcohol wipes</td>
</tr>
<tr>
<td>____ Antihistamine (relieves allergy symptoms)</td>
<td>____ Calibrated measuring spoon</td>
</tr>
<tr>
<td>____ Antiseptic (helps stop infection)</td>
<td>____ Disinfectant</td>
</tr>
<tr>
<td>____ Fever reducer (adult and child)</td>
<td>____ Gauze pads</td>
</tr>
<tr>
<td>____ Hydrocortisone (relieves itching and inflammation)</td>
<td>____ Thermometer</td>
</tr>
<tr>
<td>____ Other: ________________________</td>
<td>____ Other: ________________________</td>
</tr>
<tr>
<td>____ Other: ________________________</td>
<td>____ Other: ________________________</td>
</tr>
<tr>
<td>____ Other: ________________________</td>
<td>____ Other: ________________________</td>
</tr>
<tr>
<td>____ Other: ________________________</td>
<td>____ Other: ________________________</td>
</tr>
</tbody>
</table>

INTERNET ACTIVITY
Choose a prescription or over-the-counter drug to research. Use one or more of the following sites or do a search to find out more information about the drug.

- HealthSquare Drug Information Center: http://www.healthsquare.com/drugmain.htm
- Mayo Health (click on Drugs and Supplements): http://www.mayoclinic.com
- MedicineNet (click on Medications): http://www.medicinenet.com

Drug/medication:
Site visited (URL):
Uses for medication:
How taken (dosage/administration):
Precautions:
Side effects and drug interactions:
Other warnings and information:

Finally, compare what you’ve learned to the list of key questions provided by the U.S. Pharmacopoeia (http://www.usp.org/pdf/EN/patientSafety/justAskDozenQs.pdf). What additional information would you need to understand to safely use this medication?

There are many nondrug self-help options for mild symptoms or as an adjunct to medical treatment for various chronic conditions. Two that you might consider trying are visualization and expressive writing.

**Imagine Yourself Well**

To practice visualization, set aside 10–30 minutes of quiet, undisturbed time. Wear loose, comfortable clothing. Sit in a comfortable chair or lie on a pad or carpeted floor with a pillow under your head. Do whatever you can to enhance your comfort. Dim the lights and put on soft music if you like. Practice the technique at least three or four times a week; it will likely take several weeks of practice before you really start to notice benefits.

You can engage in a general visualization exercise for relaxation by imagining yourself in a special place that you enjoy and where you feel safe, such as a beach, a beautiful garden, or a mountain trail. Although imagery most often uses your sense of sight, you can also include the experiences of your mind’s other senses—smells, tastes, sounds, and other sensations such as a breeze on your face or sand beneath your feet—to make the experience more vivid and powerful.

You can also use imagery to focus on alleviating specific symptoms or illnesses. Use any image that is strong and vivid for you (this often involves using all your senses to create the image), and one that is meaningful to you. The image does not have to be physiologically accurate for it to work. Just use your imagination and trust yourself. The following are examples of images that some people have found useful:

- **Tension and stress**: a tight twisted rope slowly untwists; wax softens and melts; tension swirls out of your body and down the drain
- **Healing of cuts and injuries**: plaster covers over a crack in a wall; cells and fibers stick together with superglue; a shoe is laced up tight; jigsaw puzzle pieces come together
- **Pain**: all of the pain is placed in a large, strong metal box, closed, sealed tightly, and locked with a huge, strong padlock; you grasp the TV remote control and slowly turn down the pain volume until you can barely hear it, and then it disappears entirely; the pain is washed away by a cool, calm river flowing through your entire body
- **Infections**: white blood cells with flashing red sirens arrest and imprison harmful germs; an army equipped with powerful antibiotic missiles attacks enemy germs; a hot flame chases germs out of your entire body
- **Allergies, asthma, and lung diseases**: the tiny elastic rubber bands that constrict your airways pop open; a vacuum cleaner gently sucks the mucus from your airways; waves calmly rise and fall on the ocean surface; hyperalert immune cells in the fire station are reassured that the allergens have triggered a false alarm, and they can go back to playing their game of cards; the civil war ends with the warring sides agreeing not to attack their fellow citizens
- **Depression**: your troubles and feelings of sadness are attached to big colorful helium balloons and are floating off into a clear blue sky; a strong, warm sun breaks through dark clouds; you feel a sense of detachment and lightness, enabling you to float easily through your day
- **Diabetes**: small insulin keys unlock doors to hungry cells and allow nourishing blood sugar in; an alarm goes off and a sleeping pancreas awakens to the smell of freshly brewed coffee
- **Behavior change**: if you are somewhat shy, imagine a vivid, detailed picture of yourself walking up to people and chatting with them confidently; if you want to be more physically active, see yourself walking in the park, riding a bike, taking a dance class, or joining a sports team
Symptom/condition targeted: _________________________________________________________________

Imagery used (one of the previous examples or something you develop for yourself): ________________
________________________________________________________________________________________
________________________________________________________________________________________

How did you feel before and after your session of visualization? _________________________________
________________________________________________________________________________________

After several weeks of practice, did you notice any effects? ____________________________________
________________________________________________________________________________________

Expressive Journal Writing

Writing down feelings and thoughts about stressful life events has been shown to help people with chronic conditions improve their health. Use the space below to get started. Set aside a special time and write in a place where you won’t be interrupted or distracted. Choose a life event that you found particularly stressful, and write about your very deepest thoughts and feelings. You may find the writing exercise to be distressing in the short term—sadness or depression are common when dealing with feelings about a stressful event—but most people report relief and contentment soon after writing for several days. (See the specific suggestions in Wellness Worksheet 18.)
Communicating with Your Physician

The time constraints of a typical medical visit make it essential that you prepare for your visit to a health care professional and use your time to maximum advantage. To help get more out of your next medical visit, fill in the following information and use the checklist.

Before the Visit

Prepare a list of concerns, questions, and observations. Bring the list with you to the appointment and refer to it as needed.

Primary reasons for visiting physician (choose a reasonable number given the length of the scheduled appointment):

_________________________________________________________________________________________
_________________________________________________________________________________________
_________________________________________________________________________________________

Notes about symptoms (when they started, how long they last, exactly where they are located, what makes them worse and what makes them better):

_________________________________________________________________________________________
_________________________________________________________________________________________
_________________________________________________________________________________________

Special concerns about your symptoms (for example, fear of having a serious disorder or of being contagious):

_________________________________________________________________________________________
_________________________________________________________________________________________

What treatments you have already tried:

_________________________________________________________________________________________
_________________________________________________________________________________________

What you think might be causing the problem (for example, a recent camping trip or sexual encounter):

_________________________________________________________________________________________
_________________________________________________________________________________________

Medications and supplements you are currently taking:

_________________________________________________________________________________________
_________________________________________________________________________________________

Relevant medical history (allergies, pregnancy, past illnesses):

_________________________________________________________________________________________
_________________________________________________________________________________________

What you most want to get out of your visit:

_________________________________________________________________________________________
_________________________________________________________________________________________

(over)
During the Visit

The following strategies can help you get more out of a medical visit; check off those you use during your visit.

____ Present key concerns at the very beginning of the visit.
____ State concerns specifically and concisely, using the notes prepared beforehand.
____ Be open and honest about health concerns, symptoms, and physician recommendations.
____ Ask questions.
____ Participate in the decision-making process about a treatment plan.

At the End of the Visit

Before you leave the appointment, you should be able to fill in the following information; if you can’t, ask your physician for clarification or further information.

The diagnosis (the nature and cause of your symptoms):
_________________________________________________________________________________________
_________________________________________________________________________________________
_________________________________________________________________________________________

The prognosis (the expected duration, course, and outcome of the condition):
_________________________________________________________________________________________
_________________________________________________________________________________________
_________________________________________________________________________________________

The physician’s treatment recommendations and instructions—what you are supposed to do:
_________________________________________________________________________________________
_________________________________________________________________________________________
_________________________________________________________________________________________

The follow-up plan (returning for a visit, phoning for test results, reporting any specific signs or symptoms, etc.):
_________________________________________________________________________________________
_________________________________________________________________________________________
_________________________________________________________________________________________
How well do you understand the terminology used by health care providers and public health officials? See how many of the following medical and health terms you can match with their correct definitions.

___ 1. Acute
___ 2. Adverse health effect
___ 3. Additive effect
___ 4. Analgesic
___ 5. Antagonistic effect
___ 6. Atrophy
___ 7. Benign
___ 8. Carcinogen
___ 9. Chronic
___ 10. Cyst
___ 11. Degenerative disorder
___ 12. Dermal
___ 13. Diagnosis
___ 14. Edema
___ 15. Hematoma
___ 16. Incidence
___ 17. Ingestion
___ 18. In vitro
___ 19. In vivo
___ 20. Ischemia
___ 21. Lesion
___ 22. Malignant

a. A bruise
b. A change in the DNA, genes, or chromosomes of living organisms.
c. A closed, fluid-filled, or semisolid sac embedded in tissue
d. A condition characterized by deterioration of body parts that worsens over time
e. A negative or problematic change in body function
f. A response to multiple substances in which one substance amplifies the effect of another; the combined effect of the substances acting together is greater than the sum of the effects of the substances acting by themselves
g. A response to multiple substances that is equal to the sum of the effects of all the substances added together
h. A response to multiple substances that is less than would be expected if the effects of the individual substances were added together
i. A sore
j. A statement made by a government agency informing the public that a potentially hazardous condition exists, along with guidelines for avoiding or preventing exposure
k. A substance that causes cancer
l. Abnormal accumulation of fluid in the cells, especially just under the skin or in an organ such as the heart
m. Affecting the whole body
n. Aftereffects of an illness
o. Any medical technique that does not involve puncturing or entering the body
p. An assessment of the future course or outcome of a disease
q. Cancerous; tending to become worse or invasive
r. Decreased supply of oxygenated blood to any part of the body
s. Diagnostic technique of feeling, with the hands, the firmness, texture, or location of various body parts
t. Disappearance of the signs and symptoms of a disease
WELLNESS WORKSHEET 112 — continued

___ 23. Morbidity
___ 24. Mortality
___ 25. Mutation
___ 26. Noninvasive
___ 27. Palpation
___ 28. Palpitation
___ 29. Prevalence
___ 30. Prognosis
___ 31. Pruritus
___ 32. Public health advisory
___ 33. Recurrence
___ 34. Remission
___ 35. Rhinitis
___ 36. Risk
___ 37. Sepsis
___ 38. Sequelae
___ 39. Synergistic effect
___ 40. Systemic

u. In an artificial environment outside a living organism or body
v. Infection or contamination
w. Inflammation of the nasal membranes, often caused by the common cold
x. Itching
y. Noncancerous; harmless
z. Occurring over a long time
aa. Occurring over a short time
bb. Pain reliever
c. Pounding or racing of the heart
d. Referring to the skin
ee. Relating to death
ff. Relating to illness or disease; state of being ill or diseased
g. Shrinkage of muscle or tissue
hh. The act of swallowing something through eating, drinking, or mouthing objects
ii. The identification of a disease or condition, usually made by examining the patient's history, symptoms, appearance, and analysis of tests
jj. The number of cases of a disease in a certain population at a specific point in time
kk. The number of new cases of a disease in a certain population in a specific period of time
ll. The probability that something will cause injury or harm
mm. The return of a disease.
nn. Within a living organism or body

Answers: 1. aa; 2. e; 3. g; 4. bb; 5. h; 6. gg; 7. y; 8. k; 9. z; 10. c; 11. d; 12. dd; 13. ii; 14. l; 15. a; 16. kk; 17. hh; 18. u; 19. nn; 20. r; 21. i; 22. q; 23. ff; 24. ee; 25. b; 26. o; 27. s; 28. cc; 29. jj; 30. p; 31. x; 32. j; 33. mm; 34. t; 35. w; 36. ll; 37. v; 38. n; 39. f; 40. m

Scoring:
30–40 correct answers: You have an excellent grasp of commonly used health and medical terminology.
20–29 correct answers: Your knowledge of terminology is good.
10–19 correct answers: Your knowledge of terminology is fair.
Fewer than 10 correct answers: You may be at a disadvantage in communicating with your health care providers and understanding health messages.
Choosing a Health Care Plan

The following questions are designed to help you evaluate different health care plans and choose the most appropriate one for you.

Quality and Accreditation

How is the plan rated for quality? (Possible sources of ratings include the Consumer Assessment of Health Plans [CAHPS], the Health Plan Employer Data and Information Set [HEDIS], or your state health insurance commissioner.)

_________________________________________________________________________________________
_________________________________________________________________________________________
_________________________________________________________________________________________

Is the plan accredited and, if so, by what organization(s)? (Many health plans choose to be reviewed and accredited by the National Committee for Quality Assurance [NCQA], the Joint Commission, or the American Accreditation HealthCare Commission/URAC.)

_________________________________________________________________________________________
_________________________________________________________________________________________

Choice of Physician/Facilities

Are restrictions placed on your choice of physician? _____________________________________________

Is your current physician covered by the plan? ___________________________________________________

Is the hospital you prefer, or where a particular physician has privileges, covered by the plan? _______

_________________________________________________________________________________________

Are there any restrictions on your choice of clinic, hospital, or emergency room? __________________

_________________________________________________________________________________________

If you must choose a new physician or facility, are services available at convenient times and locations? _____

_________________________________________________________________________________________

Services

What services does the policy cover? Check those that are covered; circle those you are most likely to need.

___ Physician visits ___ Mental health services
___ Preventive care ___ Substance abuse treatment
___ Prescription medications ___ Prenatal care and routine deliveries
___ X rays and lab services ___ Well baby care
___ Out-of-town care ___ Ambulance service
___ Emergency room care ___ Hospitalization
___ Allergy testing and treatment ___ Second opinions

(over)
### WELLNESS WORKSHEET 113 — continued

<table>
<thead>
<tr>
<th>Category</th>
<th>Subcategory</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contraceptives</td>
<td>Surgical costs, including anesthesia</td>
</tr>
<tr>
<td>Vision care and glasses/contact lenses</td>
<td>Transfusions</td>
</tr>
<tr>
<td>Dental care</td>
<td>Skilled home nursing care</td>
</tr>
<tr>
<td>Physical therapy</td>
<td>Other: _____________________________</td>
</tr>
<tr>
<td>Complementary and alternative therapies (e.g., chiropractic)</td>
<td>Other: _____________________________</td>
</tr>
</tbody>
</table>

#### Restrictions/Exclusions

Are there exclusions for any preexisting conditions? If so, list any that would affect you: _____________________________
________________________________________________________________________________________
________________________________________________________________________________________
How long must you be free of symptoms before these would be covered? _____________________________
Is preauthorization required for any service? __________________ Which services? _______________________
________________________________________________________________________________________
Does the policy exclude particular conditions? If so, list any exclusions that may affect you: __________________
________________________________________________________________________________________
________________________________________________________________________________________

#### Costs

Monthly or yearly premium: _____________________________
Annual deductible: _____________________________
Copayments: physician visit ___________ urgent care ___________ emergency room ___________
 prescriptions ___________ hospital stay ___________ other ___________
Does the policy pay only the “usual” or “customary” fee for particular services? _______________________
Is there a maximum limit of coverage, either on a yearly basis or over the life of the policy? Are there limits on the coverage of any particular conditions? _____________________________
________________________________________________________________________________________
If you visit a physician outside the plan, what percentage of the cost is covered? _______________________
________________________________________________________________________________________
WELLNESS WORKSHEET 114

Checklist for Preventing Unintentional Injuries

Put a check next to the answer that best describes your behavior, and fill in the requested information.

Yes  No

Automobile/Truck Safety

_____  ____ I obey the speed limit at all times.

_____  ____ I follow the “3-second rule” to avoid following too closely: When the vehicle ahead passes a reference point, I count “one-thousand-one, one-thousand-two, one-thousand-three” (about 3 seconds). If I pass the reference point before I finish counting, I allow more space.

_____  ____ I slow down and allow more space between myself and the vehicle ahead when environmental conditions are not ideal (bad weather, poor road conditions, etc.).

_____  ____ I always wear a safety belt, even when the vehicle has air bags.

_____  ____ I always securely strap infants or toddlers into appropriate child safety or booster seats in the back seat of the car.

_____  ____ I never drink or use drugs and then drive.

_____  ____ I never get into a car if the driver has been drinking or using drugs.

_____  ____ I always signal when turning.

_____  ____ I avoid driving when drowsy.

_____  ____ I don’t talk on the phone while driving.

_____  ____ I always come to a complete stop at a stop sign or flashing red light.

_____  ____ I take special care at intersections: I look left, right, and then left again.

_____  ____ I don’t pass on two-lane roads unless I’m in a designated passing area (broken line) or I have a clear view of oncoming traffic.

_____  ____ When given the choice between an interstate road and a rural road, I would choose to drive on the interstate.

_____  ____ When I buy a car, safety is one of my primary considerations.

_____  ____ I keep my car in good working order and regularly check:

_____  ____ Tires

_____  ____ Brakes

_____  ____ Steering

_____  ____ Lights

_____  ____ Windshield wipers

_____  ____ Oil and fluid levels

Motorcycle/Moped Safety

_____  ____ I always wear an approved helmet.

_____  ____ I always use eye protection (goggles, eye shields, or a windshield).

_____  ____ I wear long pants and a sturdy jacket to reduce injury in case of a fall.

_____  ____ I do everything possible to make myself more visible to other motorists.

_____  ____ I wear light-colored clothing.

_____  ____ I keep my headlight on at all times.

_____  ____ I avoid changing lanes unless absolutely necessary.

_____  ____ I avoid riding between lines of moving cars.

_____  ____ I have received proper training and adequate practice, and I have the skills to operate my motorcycle/moped safely.
<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cycling Safety</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I know and follow the rules of the road.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I always ride with the flow of traffic.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I know and use proper hand signals.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I always ride defensively; I never assume that drivers have seen me.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I take special care in turning or crossing at corners and intersections.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I stop at all traffic lights and stop signs.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I keep my bike well-maintained.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I wear light-colored, reflective clothing that maximizes my visibility.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I always wear safety equipment:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Helmet</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gloves</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Appropriate footwear</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reflective equipment at night</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eye protection</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pants clips or bands</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I use bike paths whenever possible.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Pedestrian Safety</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I cross streets only in designated crosswalks.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I wait for a green light to cross the street.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I wear clothes that will make me more visible to drivers.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I never hitchhike.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Jogging Safety</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I avoid busy roadways with poor visibility when possible.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I run against the flow of traffic.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I dress to be highly visible to drivers.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I jog during the day.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I don’t listen to a radio, tape, or CD with headphones while jogging.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Swimming/Boating Safety</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I do not attempt to swim distances that are beyond my physical capabilities.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I avoid swimming in dangerous or uncertain locations or situations.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I avoid swimming long in water that is colder than 70°F (21°C).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I do not use drugs or alcohol before I swim or while boating.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I always swim with at least one other person.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>When boating, I wear an appropriate personal flotation device (PFD).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I know and follow safe boating rules.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I check water depth before diving.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Sports Safety

Yes  ____  No  ____

I participate only in those sports in which I have sufficient skill to play safely.

I recognize and guard against any hazards commonly associated with the sports I choose.

I include appropriate exercises for conditioning, warming up, and cooling down.

I use proper safety equipment and appropriate facilities (e.g., helmets, eye protection, knee and elbow pads, etc.).

I know how to recognize and avoid heat-related illness.

For the sport you most commonly participate in, list three common hazards and three pieces of needed safety equipment.

1. ___________________________  1. ___________________________
2. ___________________________  2. ___________________________
3. ___________________________  3. ___________________________

Hiking/Backpacking/Outdoor Activity Safety

Yes  ____  No  ____

I never hike or backpack alone.

I always tell someone where I am going and when I plan to return.

I always bring a map, compass, first aid kit, and emergency supplies.

I obtain weather information before any outdoor trip and dress appropriately.

I bring an adequate supply of fluids and limit strenuous activity during hot, humid weather.

I wear layers of warm clothing and covering for my head and hands when outdoors during cold weather.

I bring warm liquids and equipment for producing heat or starting fires if I will be outdoors for a prolonged period during cold weather.

Hunting/Fishing Safety

Yes  ____  No  ____

I take firearm safety and hunter safety courses regularly and follow all recommendations.

I keep firearms unloaded when they are not actively in use (including while hiking, crossing streams or ditches, or climbing over fences).

I am aware of others when casting or shooting.

I store equipment properly when it is not in use.

I store ammunition and firearms securely and separately.

Home Safety

Yes  ____  No  ____

Rugs and carpets are skid-proof.

Bathtubs have handrails and non-slip mats.

Floors are kept clear of conditions and objects that can cause slippage.

Liquids  ____  Sand or gravel  ____

Heavy wax coating  ____  Small objects (e.g., toys)  ____

Electrical cords  ____

(over)
<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Driving Like a Pro

Along with safe cars, safety belts, air bags, and sobriety, driving skills are an important element in motor vehicle safety. Learn to drive defensively, avoiding dangerous situations and reacting intelligently in a crisis. To find out how well you drive already, try this defensive-driving quiz. (Some questions have more than one correct answer.)

1. The safest way to brake is
   a. as fast as possible.
   b. as far in advance as possible.

2. In moderate town traffic, with another car at a safe distance in front of you, you're being tailgated. What do you do?
   a. Tap the brakes and start to slow down—gradually—keeping an eye on the rearview mirror.
   b. Increase your speed to the allowable limit.
   c. Try to pass the car in front of you.
   d. Pull over to the right.

3. You are traveling 30 mph on a dry road. Safe following distance is
   a. 1 car length.
   b. 2 car lengths.
   c. 5 car lengths.

4. Preparing to change lanes on a multilane highway, which of the following should you do?
   a. Check your rearview mirror.
   b. Check your side mirror.
   c. Take your eyes off the road momentarily and glance at the lane you're planning to move into.
   d. Turn on your directional signal.
   e. Be aware of what traffic in front of you is doing.

5. You've swerved to the right to avoid a collision on a two-way highway, and your right wheels drop off the pavement and are riding on the shoulder. To get back on the road, you
   a. accelerate, cutting the wheel to the left.
   b. don't brake but take your foot off the accelerator. Hold the wheel steady. When the car slows, check the traffic and steer back onto the pavement.
   c. brake sharply and try to pull off the road altogether. When you've got the car under control, pull onto the road again.

6. On a two-way highway, in what's clearly marked as a no-pass zone with limited visibility, a car pulls out to pass you. Your best move is to
   a. speed up, hoping the car will move back behind you.
   b. ignore the car—it's not your problem.
   c. reduce your speed so the car can get around you faster.

7. The most important factor in defensive driving is
   a. quick reflexes.
   b. anticipating trouble.
   c. skill at vehicle handling.
   d. strict observation of the law.

8. Which of the following road conditions up ahead should tell you to reduce your speed?
   a. a deep pothole
   b. leaves on the pavement
   c. any bridge when the temperature is just above freezing

9. Your rear-wheel-drive car is skidding (see diagram). What's the safest reaction?
   a. Turn the wheel to the right.
   b. Turn the wheel to the left.
   c. Brake as hard as possible and avoid turning the wheel until you've stopped the car.
10. In two-way highway traffic, an oncoming car suddenly pulls into your lane. What action do you take?
   a. Brake hard and sound your horn.
   b. Move quickly into the left lane.
   c. Blow your horn and head to the shoulder.

11. The best position for your hands on the steering wheel is
   a. at the 10:00 and 2:00 positions.
   b. at the 8:00 and 4:00 positions.
   c. wherever you’re most comfortable.
   d. at the 9:00 and 3:00 positions.

12. True or false: Underinflated tires are safer, particularly in hot weather.

---

**Answers**

1. (b) A basic principle of defensive driving is never to get into a situation that calls for slamming on the brakes. This can throw you into a skid and injure you and your passengers.

2. (a) and (d), depending on circumstances. If the tailgater is daydreaming, tapping your brakes (and activating the brake lights) should wake him or her up. If the driver is being aggressive, you’ve politely given a signal to let up. If the tailgating doesn’t stop, pull over as soon as you can and let the other car pass.

3. (c) On a dry road, going 30 mph, give yourself 2 to 3 seconds to stop, or about 5 car lengths. If you are driving faster, if the road is wet, if visibility is poor, or if you are tired, drop back more. To determine how close you are following, notice when the rear of the vehicle ahead passes a tree or other fixed point. Then count “one thousand one, one thousand two,” and so on until you pass the same fixed point.

4. (all) All steps are essential, but some people forget (c). You always have a blind spot (about a car length behind you on either side) and may not be able to see an overtaking vehicle in either mirror. Always glance over your shoulder before making your move. The signal light turned on several seconds in advance will help protect you as well.

5. (b) Braking hard or jerking the wheel can cause you to skid into oncoming traffic. Don’t brake but do reduce your speed and stay on a steady course. Then, after checking traffic, make a sharp quarter turn to the left to put yourself back on the road and then straighten out.

6. (c) Passing is always a cooperative venture. If this reckless driver has a head-on collision, you might be hurt too.

7. (b) Obeying the law and vehicle-handling skills are all important. But anticipating trouble up ahead and acting to prevent it can make the speed of your reflexes far less important and thus may prevent many collisions.

8. (all) The pothole may only jar you, but it could damage your car or even cause you to lose control. Leaves can send you into a skid. And even though there’s no ice on the road, a bridge is about 6°F (3°C) colder than a highway and may be hazardous when the road is not.

9. (b) Turn the wheel straight down your lane. That is, if your rear wheels are skidding left, as in the diagram, turn with the skid—that is, to the left. Don’t brake; it increases skidding.

10. (c) Don’t move left, which could put you in someone else’s pathway. Always move right when heading off the road.

11. (d) And some expert drivers recommend that you hook your thumbs lightly over the horizontal spokes. This gives you a feel for the front tires and is a good way to get a quick grip if you strike a pothole.

12. False. An underinflated tire is more likely to skid, whether in hot weather or on wet or icy pavement. Because underinflation allows a tire to “flap” slightly and thus to create more heat, it’s also more likely to blow out. Even for desert driving, keep tires at the recommended maximum air pressure and check them weekly. The number should be printed on the side of the tires; or check the instruction manual if the car still has its original tires.

---

**SOURCE:** Adapted from Driving through the 90s. 1994. University of California at Berkeley Wellness Letter, July; and Driving like the pros. 1989. University of California at Berkeley Wellness Letter, October. Reprinted by permission from the University of California at Berkeley, Wellness Letter. Copyright © 1989, 1994 University Health Publishing Group, LLC. www.wellnessletter.com
WELLNESS WORKSHEET 116

Are You an Aggressive Driver?

To find out if you are an aggressive driver, check any of the following statements that are true for you:

_____ I consistently exceed the speed limit; I’m often unaware of both my speed and the speed limit.

_____ I frequently follow closely behind the car in front of me.

_____ If I feel the car in front of me is going too slowly, I tailgate.

_____ I change lanes frequently to pass people.

_____ I seldom use my turn signal when changing lanes or turning.

_____ I often run red lights or roll through stop signs.

_____ I react to what I feel is another driver’s mistake by cursing, shouting, or making rude gestures; by blocking a car from passing or changing lanes; by using high beams; or by braking suddenly in front of a tailgater.

_____ My personality changes and I become more competitive when I get behind the wheel.

_____ I often get angry or impatient with other drivers and with pedestrians.

_____ I would consider pulling over for a personal encounter with a bad driver.

Each of these statements is characteristic of aggressive drivers; the more items you checked, the greater your road rage. If you checked even one statement, try the following steps to reduce your hostility the next time you get behind the wheel.

_____ Allow enough time for your trip to reach your destination without speeding.

_____ Avoid driving during periods of heavy traffic.

_____ Don’t drive when you are angry, tired, or intoxicated.

_____ Imagine that the other drivers are all people that you know and like. Be courteous and forgiving.

_____ Listen to soothing music or a book on tape, or practice a relaxation technique such as deep breathing.

Develop at least two additional strategies that work for you:

1. ______________________________________________________________________________________

2. ______________________________________________________________________________________

If road rage is still a problem for you, take a course in anger management.

Even if you are successful at controlling your own aggressive driving impulses, you may still encounter an aggressive driver on the road. The AAA Foundation for Traffic Safety recommends the following strategies to avoid being a victim of an aggressive driver.

• Avoid behaviors that may enrage an aggressive driver; these include cutting cars off when merging, driving slowly in the left lane, tailgating, and making rude gestures.

• If you make a mistake while driving, apologize. In surveys, the most popular and widely understood gestures for apologies include raising or waving a hand and touching or knocking the head with the palm of your hand (to indicate “What was I thinking?”).

• Refuse to join in a fight. Avoid eye contact with an angry driver, and put distance between your car and his or her vehicle. If you think another driver is following you or trying to start a fight, call the police on a cell phone or drive to a public place.
Think of two additional strategies for dealing with an aggressive driver:
1. ______________________________________________________________________________________
2. ______________________________________________________________________________________

INTERNET ACTIVITY
To further assess your risk for aggressive driving, take the quiz at the Web site for the AAA Foundation for Traffic Safety (http://www.aaafoundation.org/quizzes).

How did you score? Did the results indicate that aggressive driving may be a problem for you?

Research additional strategies for reducing your own road rage and for avoiding other aggressive drivers. Identify three strategies for avoiding problems associated with aggressive driving—your own or that of another driver. Visit one or more of the sites listed below or perform a search.

Aggressive Driving Issues Conference: http://www.aggressive.drivers.com
National Highway Transportation Safety Administration: Aggressive Driving:
New York State Department of Motor Vehicles: Aggressive Driving:
   http://www.nysgtsc.state.ny.us/aggr-ndx.htm

Site(s) visited (URL): __________________________________________________________________________

Strategies for reducing aggressive driving:
1. ______________________________________________________________________________________
2. ______________________________________________________________________________________
3. ______________________________________________________________________________________
WELLNESS WORKSHEET 117

Personal Safety Checklist

Are you doing all you can to protect yourself from violence and injuries? The following list of statements relate to intentional injury incidents that can occur in a variety of settings. Put a check next to those statements that are true for you and fill in the requested information.

At Home

____ My home has good lighting.
____ Doors are secured with effective locks (deadbolts).
____ All unused doors and windows are securely locked.
____ I always lock all windows and doors when I go out.
____ I have a dog and/or post “Beware of Dog” signs.
____ Landscaping around the home doesn’t provide opportunities for concealment.
____ Keys are hidden in a secure, nonobvious place.
____ I do not give anyone the opportunity to duplicate my keys.
____ The front door has a peephole.
____ I do not open my door to strangers or allow them into my home or yard.
____ I ask to see ID or call to verify that repair and utility workers are legitimate.
____ I use my initials in phone directory listings.
____ My answering machine message does not imply that I live alone or am not home.
____ Everyone in the household knows how to call for help.
____ My neighbors and I have a system for alerting one another in case of an emergency.
____ I participate in a neighborhood watch program.

On the Street

____ I avoid walking alone, especially at night or in less-populous areas.
____ I dress in clothing that allows freedom of movement.
____ I walk purposefully, in an alert and confident manner.
____ I walk on the outside of the sidewalk, facing traffic.
____ I check routes to my destination before leaving so as not to appear lost.
____ I never hitchhike.
____ I carry valuables in a secure or concealed location and take special care at ATMs.
____ I have my keys ready when I approach my vehicle or home.
____ I carry a cell phone or change for a public phone, fare for public transportation, and a whistle to blow if I am attacked or harassed.
____ I keep alert for suspicious behavior, and I keep at least two arm lengths between myself and strangers.

(over)
In My Car

___ My car is in good working condition.
___ I carry emergency supplies in my car.
___ I keep my gas tank at least half full.
___ When driving, I keep doors locked and windows rolled up at least three-quarters of the way.
___ I park my car in well-lighted areas or parking garages.
___ I lock my car when I leave it.
___ I check the interior of my car before unlocking it and getting in.
___ I don’t pick up strangers.
___ I note the location of emergency call boxes, or I have a cell phone in my car.
___ I use caution if my car breaks down or if I am involved in a minor crash or bumped intentionally.
___ When I stop at a light or stop sign, I stop far enough behind the car in front to allow room to maneuver in case of emergency.
___ I do not get into arguments with drivers of other vehicles.

On Public Transportation

___ I wait in populated, well-lighted areas.
___ I sit near the driver or conductor.
___ I sit in a single seat or an outside seat.
___ I check routes and times in advance, and confirm before boarding that the bus, subway, or train is bound for my destination.

On Campus

___ The door and window locks where I live are secure.
___ The halls and stairwells where I live have adequate lighting.
___ Dorm doors are not left unlocked or propped open.
___ I do not give dorm or residence keys to others.
___ I keep my door locked.
___ I do not allow strangers into my room.
___ I do not walk, jog, or exercise alone at night.
___ I use campus escort services or walk with friends.
___ I know the areas that security guards patrol and stay where they can see or hear me if possible.

Your answers here can help you identify behaviors that you should change. Consider planning a behavior change strategy to alter one or more of your risky behaviors.
WELLNESS WORKSHEET 118

Violence in Relationships

Part I. Recognizing the Potential for Abusiveness

If you are concerned that a man you are involved with has the potential for violence, observe his behavior and ask yourself these questions.

1. What is this person’s attitude toward women? How does he treat his mother and his sister? How does he work with female students, female colleagues, or a female boss? How does he treat your women friends?

2. What is his attitude toward your autonomy? Does he respect the work you do and the way you do it? Or does he put it down, or tell you how to do it better, or encourage you to give it up? Does he tell you he’ll take care of you?

3. How self-centered is he? Does he want to spend leisure time on your interests or his? Does he listen to you? Does he remember what you say?

4. Is he possessive or jealous? Does he want to spend every minute with you? Does he cross-examine you about things you do when you’re not with him?

5. What happens when things don’t go the way he wants them to? Does he blow up? Does he always have to get his way?

6. Is he moody, mocking, critical, or bossy? Do you feel as if you’re “walking on eggshells” when you’re with him?

7. Do you feel you have to avoid arguing with him?

8. Does he drink too much or use drugs?

9. Does he refuse to use condoms or take other precautions for safer sex?
Experts summarize their advice to women this way: Listen to your own uneasiness, and stay away from any man who disrespects women, who wants or needs you intensely and exclusively, and who has a knack for getting his own way almost all the time.

Part II. Recognizing Signs of Abuse

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Does your partner constantly criticize you, blame you for things that are not your fault, or verbally degrade you?</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>Does he humiliate you in front of others?</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>Is he suspicious or jealous? Does he accuse you of being unfaithful or monitor your mail or phone calls?</td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>Does he “track” all your time? Does he discourage you from seeing friends and family?</td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>Does he prevent you from getting or keeping a job or attending school? Does he control your shared resources or restrict your access to money?</td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>Has he ever pushed, slapped, hit, kicked, bitten, or restrained you? Thrown an object at you? Used a weapon on you?</td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td>Has he ever destroyed or damaged your personal property or sentimental items?</td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td>Has he ever forced you to have sex or to do something sexually you didn’t want to do?</td>
<td></td>
</tr>
<tr>
<td>9.</td>
<td>Does he anger easily when drinking or taking drugs?</td>
<td></td>
</tr>
<tr>
<td>10.</td>
<td>Has he ever threatened to harm you or your children, friends, pets, or property?</td>
<td></td>
</tr>
<tr>
<td>11.</td>
<td>Has he ever threatened to blackmail you if you leave?</td>
<td></td>
</tr>
</tbody>
</table>

If you answered “yes” to one or more of these questions, you may be experiencing domestic abuse. If you believe you or your children are in imminent danger, look in your local telephone directory for a women’s shelter, or call 9-1-1. If you want information, referrals to a program in your area, or assistance, contact one of the organizations listed in For More Information in Chapter 21 of your textbook (Chapter 16 in the brief version).

INTERNET ACTIVITY

Research Web resources relating to date rape or domestic violence; use the Web sites listed in your text and/or do a Web search. What resources are available for victims and abusers? Are referrals to support groups or legal help provided? Are there suggestions for friends of victims or concerned citizens and communities? Write a brief description of the most helpful site you locate.

Topic: __________________________________________

Site visited (URL): _____________________________

Description:

Recognizing Warning Signs of Violence in Others

Often people who act violently have trouble controlling their feelings. They may have been hurt by others. Some think that making people fear them through violence or threats of violence will solve their problems or earn them respect. This isn’t true. People who behave violently lose respect. They find themselves isolated or disliked, and they still feel angry and frustrated. One way to address the problem of violence is to learn to recognize and react to potential signs of violent behavior. If you notice the following signs over a period of time, the potential for violence exists (check any that apply).

If someone you know shows warning signs of violence, there are things you can do. Above all, be safe. Don’t spend time alone with people who show warning signs. If possible without putting yourself in danger, remove the person from the situation that’s setting him or her off. Tell someone you trust and respect about your concerns and ask for help. This could be a family member, guidance counselor, teacher, school psychologist, coach, clergy, school resource officer, or friend. If you are worried about being a victim of violence, get someone in authority to protect you. Do not resort to violence or use a weapon to protect yourself.

Controlling Your Own Risk for Violent Behavior

Complete the checklist for your own behavior. If you recognize any of the warning signs for violent behavior in yourself, get help. You don’t have to live with the guilt, sadness, and frustration that comes from hurting others. Admitting you have a concern about hurting others is the first step. The second is to talk to a trusted person such as a school counselor or psychologist, teacher, school psychologist, coach, clergy, school resource officer, or friend. They can get you in touch with a licensed mental health professional who can help.

It’s normal to feel angry or frustrated when you’ve been let down or betrayed. But anger and frustration don’t justify violent action. Anger is a strong emotion that can be difficult to keep in check, but the right response is always to stay cool. Try the following methods of dealing with anger without resorting to violence:

(over)
Learn to talk about your feelings—if you’re afraid to talk or if you can’t find the right words to describe what you’re going through, find a trusted friend or adult to help you one-on-one.

Express yourself calmly—express criticism, disappointment, anger, or displeasure without losing your temper or fighting. Ask yourself if your response is safe and reasonable.

Listen to others—listen carefully and respond without getting upset when someone gives you negative feedback. Ask yourself if you can really see the other person’s point of view.

Negotiate—work out your problems with someone else by looking at alternative solutions and compromises.

Everyone feels anger in his or her own way. Start managing it by recognizing how anger feels to you. When you are angry, you probably feel muscle tension, accelerated heartbeat, a “knot” or “butterflies” in your stomach, changes in your breathing, trembling, goose bumps, and flushed in the face. You can reduce the rush of adrenaline that’s responsible for your heart beating faster, your voice sounding louder, and your fists clenching if you try the following:

- Take a few slow, deep breaths and concentrate on your breathing.
- Imagine yourself at the beach, by a lake, or anywhere that makes you feel calm and peaceful.
- Try other thoughts or actions that have helped you relax in the past.
- Keep telling yourself “Calm down,” “I don’t need to prove myself,” or “I’m not going to let him/her get to me.”

Stop. Consider the consequences. Think before you act. Only you have the power to control your own violent behavior; don’t let anger control you.

**INTERNET ACTIVITY**

Choose one type of violence to investigate, and write a brief description of current U.S. trends. How common is this type of violence? What are the typical characteristics of perpetrators and victims? Is this type of violence increasing or decreasing? What are some of the risk factors associated with it? Use the sites listed in your text or perform a search. Statistics and background information on many types of violence in the United States are available at the following sites:

- Bureau of Justice Statistics: http://www.ojp.usdoj.gov/bjs
- Federal Bureau of Investigation: http://www.fbi.gov
- National Criminal Justice Reference Service: http://www.ncjrs.org

Site(s) visited (URL):

Type of violence:

Discussion:

SOURCE: Recognizing Warning Signs of Violence in Others, Controlling Your Own Risk for Violent Behavior, and the methods for dealing with anger have been adapted from “Warning Signs of Youth Violence.” Copyright © 2004 by the American Psychological Association. Adapted with permission. See http://apahelpcenter.org to view the full document and for other information on psychological issues affecting physical and emotional well-being. No further reproduction or distribution is permitted without written permission from the American Psychological Association.
Building a Kit of Emergency Supplies for Your Household

A kit with the supplies listed below can help you and those in your household prepare for both natural and man-made emergencies. Check off items as you add them to your kit. Keep your kit in a designated place so that you can retrieve it quickly in case you need to be evacuated. Put together a smaller kit to keep in your car and at your place of work.

**Basic Emergency Supplies**

- Map of the area for help in evacuating or locating shelters
- Cash (including change) and credit cards
- Copies of important documents (stored in a watertight container)
- Emergency contact list and phone numbers
- Extra sets of house and car keys
- Flashlight
- Battery- or solar-powered radio
- Battery-powered alarm clock
- Extra batteries
- Cell phone and/or prepaid phone card
- Signal flares
- Fire extinguisher (small canister A-B-C type)
- Whistle
- Tube tent
- Sleeping bags or warm blankets (one per person)
- Complete change of warm clothing and footwear (jacket or coat, long pants, long-sleeved shirt, sturdy shoes, hat, gloves, raingear, extra socks and underwear, sunglasses)
- Work gloves
- Pliers
- Shut-off wrench for gas and water supplies
- Shovel, hammer, and other tools
- Compass
- Matches in a waterproof container
- Aluminum foil
- Plastic storage containers
- Duct tape and scissors
- Paper, pens, pencils
- Needles and thread
- Medicine dropper
WELLNESS WORKSHEET 120 — continued

First Aid Kit
   — First aid manual
   — Thermometer
   — Scissors
   — Tweezers
   — Safety pins
   — Needle
   — Latex or other sterile gloves
   — Sterile gauze pads
   — Cleansing agent (soap, isopropyl alcohol, or antiseptic towelettes)
   — Sunscreen
   — Antibiotic ointment
   — Burn ointment
   — Petroleum jelly or another lubricant
   — Sterile adhesive bandages in several sizes
   — Sterile roller bandages
   — Triangular bandages
   — Cotton balls
   — Eyewash solution
   — Aspirin or nonaspirin pain reliever
   — Antidiarrhea medication
   — Laxative
   — Antacid
   — Activated charcoal (use if advised by Poison Control Center)
   — Potassium iodide (use following radiation exposure if advised by local health authorities)
   — Prescription medications and prescribed medical supplies
   — List of medications, dosages, and any allergies (for each household member)

Special Needs Items
   — Infant care needs (formula, bottles, diapers, powdered milk, diaper rash ointment)
   — Extra eye glasses
   — Contact lenses and supplies
   — Denture needs
   — Hearing aid or wheelchair batteries; other special equipment

(over)
WELLNESS WORKSHEET 120 — continued

___ Pet care supplies
___ Other (list): ___________________________________________________________
___ Other (list): ___________________________________________________________

Food and Related Supplies
___ Manual (non-electric) can opener
___ Utility knife
___ Eating utensils: Mess kits, or paper cups and plates and plastic utensils
___ Sugar, salt, pepper
___ Paper towels
___ Plastic garbage bags and resealing bags
___ Small cooking stove and cooking fuel (if food must be cooked)
___ Water: Three-day supply, at least one gallon of water per person per day, stored in clean plastic containers such as soft drink bottles:

Number of people: _____ × 1 gallon/day × 3 days = ____ Total minimum gallons of water

Store additional water if you live in a hot climate or if your household includes infants, pregnant women, or people with special health needs. Containers can be sterilized by rinsing them with a diluted bleach solution (one part bleach to ten parts water). Replace your water supply every 6 months.

___ Food: At least a 3-day supply of nonperishable foods—those requiring no refrigeration, preparation, or cooking and little or no water. Choose foods from the following checklist and expand the list with foods that members of your household will eat. Replace items in your food supply every 6 months

<table>
<thead>
<tr>
<th>Ready-to-eat canned meats, fruits, and vegetables</th>
<th>Comfort/stress foods</th>
</tr>
</thead>
<tbody>
<tr>
<td>Protein or fruit bars</td>
<td>Vitamins</td>
</tr>
<tr>
<td>Dry cereal or granola</td>
<td>Infant foods</td>
</tr>
<tr>
<td>Peanut butter</td>
<td>Pet foods</td>
</tr>
<tr>
<td>Dried fruit</td>
<td>Other:</td>
</tr>
<tr>
<td>Nuts</td>
<td>Other:</td>
</tr>
<tr>
<td>Crackers</td>
<td>Other:</td>
</tr>
<tr>
<td>Canned or boxed juices</td>
<td>Other:</td>
</tr>
<tr>
<td>Nonperishable pasteurized milk or powdered milk</td>
<td>Other:</td>
</tr>
<tr>
<td>High-energy foods</td>
<td>Other:</td>
</tr>
</tbody>
</table>

Sanitation
___ Plastic garbage bags (and ties)
___ Toilet paper
___ Moist towelettes

(over)
WELLNESS WORKSHEET 120 — continued

___ Washcloth and towel
___ Personal hygiene items (toothbrush, shampoo, deodorant, comb, shaving cream, and so on)
___ Plastic bucket with tight lid
___ Disinfectant
___ Household chlorine bleach
___ If possible, a small shovel for digging a latrine

For a Clean Air Supply
___ Face masks OR several layers of dense-weave cotton material (handkerchiefs, t-shirts, towels) that fit snugly over your nose and mouth. Each household member should have his or her own nose and mouth protection that fits tightly to help filter out contaminants.
___ Shelter-in-place supplies, to be used in an interior room in your home to create a barrier between you and potentially contaminated air outside.
    ___ Heavyweight plastic garbage bags or plastic sheeting
    ___ Duct tape
    ___ Scissors
    ___ If possible, a portable air purifier with a HEPA filter

Family Emergency Plan
___ Plan places where your family will meet; choose one location near your home and one outside your neighborhood.
    Local: __________________________________________________________
    Outside neighborhood: ____________________________________________
___ Make sure children know where to go or whom to contact in case of an emergency.
___ Post emergency numbers and instructions.
___ Have one local and one out-of-state contact person for family members to call if separated during a disaster. (It may be easier to make long-distance calls than local calls.)
    Local: __________________________________________________________
    Out-of-state: ____________________________________________________
___ Know how to shut off water, gas, and electricity; keep the necessary tools near the shut-off valves.
___ Talk with your neighbors: Who has specialized equipment (for example, a power generator) or expertise that might help in a crisis? Do elderly or disabled neighbors have someone to help them?
___ Take a first aid class.

**WELLNESS WORKSHEET 121**

**Are You Prepared for Aging?**

### Assess Your Current Behaviors

Are you doing everything you can now to enhance the quality of your life as you age? Read through the following list of statements and check the answer that best describes your current behavior.

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>I exercise regularly.</td>
</tr>
<tr>
<td>____</td>
<td>____</td>
<td>I eat wisely.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>I eat meals low in fat and added sugars and high in essential nutrients and fiber (fresh fruits and vegetables, whole-grain cereals and breads, brown rice, pasta).</td>
</tr>
<tr>
<td></td>
<td></td>
<td>I limit saturated and trans fats and get protein from fish, skinless poultry, and plant sources.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>I use fat-free or low-fat dairy products.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>I consume the recommended amount of calcium, vitamin D, and vitamin B-12.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>I limit the amount of sodium I consume and consume adequate potassium.</td>
</tr>
<tr>
<td>____</td>
<td>____</td>
<td>My weight is in the recommended range.</td>
</tr>
<tr>
<td>____</td>
<td>____</td>
<td>I drink alcohol in moderation, if at all.</td>
</tr>
<tr>
<td>____</td>
<td>____</td>
<td>I don’t use tobacco in any form.</td>
</tr>
<tr>
<td>____</td>
<td>____</td>
<td>I recognize the stressors in my life and take appropriate steps to control and deal with stress.</td>
</tr>
<tr>
<td>____</td>
<td>____</td>
<td>I perform appropriate self-examinations.</td>
</tr>
<tr>
<td>____</td>
<td>____</td>
<td>I have regular physical examinations that include appropriate screening tests.</td>
</tr>
<tr>
<td>____</td>
<td>____</td>
<td>I participate in activities that keep my mind sharp and active.</td>
</tr>
</tbody>
</table>

### Thinking About Aging

Have you thought seriously about the changes that aging can bring? To help you begin thinking now about your life as you grow older, answer the following questions.

1. What things come to mind when you think of an older person? Can you imagine those things applying to you? What do you think you will be like when you are 70 years old?

2. What do you most look forward to as you grow older?
3. What do you most fear as you grow older?

4. How long would you like to keep working? What would you like to do after you retire? What hobbies or volunteer opportunities would you pursue?

5. Have you considered the loss of income that retirement often brings? What can you do now to help meet your economic needs in the future?

6. Older people often find themselves alone more frequently (due to the death of a spouse and/or close friends). Can you think of activities you enjoy doing alone?

7. If when you are older you are no longer able to care for yourself, what living and care arrangements would you prefer?

8. What would you do if your parents were no longer able to care for themselves?

9. List five positive and five negative things about aging.
WELLNESS WORKSHEET 122
The Eight Dimensions of Successful Retirement Self-Assessment

Throughout our lives we have passed through many stages of development and change. This self-assessment has been created to help you explore and reflect upon eight life dimensions that are related to a successful retirement. There are no right or wrong answers.

Instructions: Review each item within each of the Eight Dimensions and circle the number, from 0 (lowest) to 5 (highest), that best reflects your current level of satisfaction with that item.

A comments section has been included with each dimension for you to include additional thoughts and reflections after you have completed the exercise.

Dimension 1 : Self-Discovery & Renewal

1. Level of spirituality
   0  1  2  3  4  5
2. Commitment to personal core values
   0  1  2  3  4  5
3. Self-maintenance and development activities
   0  1  2  3  4  5
4. Personal focus and search for meaning
   0  1  2  3  4  5
5. Development of new skills and interests
   0  1  2  3  4  5

Comments: _______________________________________________________________________________
_________________________________________________________________________________________

Dimension 2: Financial & Legal Stewardship

1. Current financial resources
   0  1  2  3  4  5
2. Future financial resources
   0  1  2  3  4  5
3. Financial planning, goals and objectives
   0  1  2  3  4  5
4. Relationship of other goals with financial resources
   0  1  2  3  4  5
5. Asset and health care protection
   0  1  2  3  4  5

Comments: _______________________________________________________________________________
_________________________________________________________________________________________

(over)
Dimension 3: Health & Wellness

1. Diet and nutrition 0 1 2 3 4 5
2. Level of exercise/physical activity 0 1 2 3 4 5
3. Health appraisal 0 1 2 3 4 5
4. Goals and objectives 0 1 2 3 4 5
5. Factors affecting health (smoking, alcohol, drugs, etc.) 0 1 2 3 4 5

Comments: _______________________________________________________________________________
_________________________________________________________________________________________

Dimension 4: Meaning & Purpose—Continuing to Contribute

1. Volunteer activities 0 1 2 3 4 5
2. Working—full or part time 0 1 2 3 4 5
3. Service organization involvement 0 1 2 3 4 5
4. Family support and involvement 0 1 2 3 4 5
5. Feeling of meaning and purpose 0 1 2 3 4 5

Comments: _______________________________________________________________________________
_________________________________________________________________________________________

Dimension 5: Staying Sharp—Mental Fitness

1. Continuing to learn 0 1 2 3 4 5
2. Self-esteem 0 1 2 3 4 5
3. Exploring new opportunities 0 1 2 3 4 5
4. Future outlook 0 1 2 3 4 5
5. Personal goals and objectives 0 1 2 3 4 5

Comments: _______________________________________________________________________________
_________________________________________________________________________________________

(over)
**Dimension 6: Relationships**

1. Quality of interactions with family members  
   0 1 2 3 4 5  
2. Quantity of interactions with family members  
   0 1 2 3 4 5  
3. Quality of interactions with others  
   0 1 2 3 4 5  
4. Quantity of interactions with others  
   0 1 2 3 4 5  
5. Connections with other groups  
   0 1 2 3 4 5  

Comments: _______________________________________________________________________________  
_________________________________________________________________________________________

**Dimension 7: Peak Experiences**

1. Hobbies  
   0 1 2 3 4 5  
2. Travel  
   0 1 2 3 4 5  
3. Sports and related activities  
   0 1 2 3 4 5  
4. Cultural activities  
   0 1 2 3 4 5  
5. Clubs, associations, group membership  
   0 1 2 3 4 5  

Comments: _______________________________________________________________________________  
_________________________________________________________________________________________

**Dimension 8: Home Base**

1. Geographical preference  
   0 1 2 3 4 5  
2. Suitability/type of residence  
   0 1 2 3 4 5  
3. Access to resources and activities  
   0 1 2 3 4 5  
4. Climate  
   0 1 2 3 4 5  
5. Congruity with financial resources  
   0 1 2 3 4 5  

Comments: _______________________________________________________________________________  
_________________________________________________________________________________________
### Scoring Instructions:

1. Add your “scores” for each item within each dimension to get a total score for that dimension. Record your score for each dimension below.
2. Divide that total by 5 to get an average score for the dimension.
3. List the average score for each dimension in the chart below.

<table>
<thead>
<tr>
<th>Dimension</th>
<th>Total Score</th>
<th>Avg. Score (Total ÷ 5)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Self-Discovery &amp; Renewal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Financial &amp; Legal Stewardship</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Health &amp; Wellness</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Continuing to Contribute</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Mental Fitness</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Relationships</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Peak Experiences</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Home Base</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

4. Plot your Average Satisfaction Scores on the following line chart.

```
<p>| | | | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D-1</td>
<td>D-2</td>
<td>D-3</td>
<td>D-4</td>
<td>D-5</td>
<td>D-6</td>
<td>D-7</td>
</tr>
</tbody>
</table>
```

5. Connect the dots with straight lines to complete your line chart.
Part I. Osteoporosis Risk Assessment

Complete the following questionnaire to determine your risk for developing osteoporosis.

Yes  No
1. Do you have a small, thin frame and/or are you Caucasian or Asian?
2. Have you or a member of your immediate family broken a bone as an adult?
3. Are you a postmenopausal woman?
4. Have you had an early or surgically induced menopause?
5. Have you taken high doses of thyroid medication or used glucocorticoids ≥ 5 mg a day (for example, prednisone) for 3 or more months?
6. Have you taken, or are you taking, immunosuppressive medications or chemotherapy to treat cancer?
7. Is your diet low in dairy products and other sources of calcium?
8. Are you physically inactive?
9. Do you smoke cigarettes or drink alcohol in excess?

The more times you answer “yes,” the greater your risk for developing osteoporosis. See your health care provider, and contact the National Osteoporosis Foundation (NOF) for more information.

Part II. Do You Get Enough Calcium?

Write in the number of servings of each of the following types of calcium-rich foods you eat on an average day. Typical serving sizes are given for each.

### High Calcium-Rich Foods

**Milk and Milk Products**
- nonfat or low-fat milk or buttermilk (1 cup)
- low-fat chocolate milk (1 cup)
- reduced-fat milk, unflavored or chocolate (1 cup)
- nonfat, low-fat, or regular yogurt (1 cup)
- low-fat cheese or mozzarella (1 1/2 oz)
- whole milk, unflavored or chocolate (1 cup)
- milkshake made with milk (1 cup)
- hot chocolate made with milk (1 cup)
- pudding, custard, or flan, made with milk (1 cup)
- blended coffee drinks, e.g. lattes or mochas (1 1/2 cup)
- hard cheese (1 1/2 oz)
- processed cheese (2 oz)

**Meat, Beans, and Nuts**
- tofu processed with calcium (1/2 cup)
- sardines with bones (6)

### Medium Calcium-Rich Foods

**Milk and Milk Products**
- nonfat, low-fat, or regular cottage cheese (1/2 cup)
- cream soup (1 cup)
- ice milk, frozen yogurt, or ice cream (1/2 cup)

**Meats, Beans, and Nuts**
- dried beans, peas, or refried beans (1 cup)
- canned fish with bones (2 oz)
- tofu processed with calcium (1/2 cup)
- almonds (1/4 cup)

**Vegetables & Fruits**
- bok choy (1/2 cup)
- broccoli (1 cup)
- kale (1 cup)
- mustard greens (1 cup)
- turnip greens (1/2 cup)
- spinach (1 cup)
- figs (5)

**Total servings of high calcium-rich foods**

**Total servings of medium calcium-rich foods**
Three servings of medium calcium-rich foods equal one high calcium-rich serving, so divide the total servings of medium calcium-rich foods by 3 before totaling your daily servings:

\[ \text{servings of high calcium-rich foods} + \left( \frac{\text{servings of medium calcium-rich foods}}{3} \right) = \text{total calcium servings} \]

2–3 total servings = about 1000–1200 mg of calcium
3–4 total servings = about 1200–1500 mg of calcium

Refer to the Nutrition Resources section in your text, and fill in the calcium recommendation for people of your sex and age: \( \text{mg calcium/day} \)

How does your intake compare? If it’s too low, consider planning a behavior change strategy that focuses on increasing calcium intake. Once you have a better idea of how many servings of calcium-rich foods you should consume, you can do a quick online calcium intake check by taking the Calcium Quiz at the Web site for the Dairy Council of California (http://www.dairycouncilofca.org); click on “Tools” from the home page.

**INTERNET ACTIVITY**

Choose one of the potential physical challenges of growing older—osteoporosis, arthritis, hearing loss, Alzheimer’s disease, glaucoma, and so on; if possible, choose one that has affected a member of your family or someone you know. Do a Web search to identify strategies for both preventing the problem and coping with the problem if it does occur. (Coping strategies can apply to either the affected person or to her or his caregivers.)

Challenge/problem:

Site(s) visited (URL):

Strategies for prevention (list at least three):

Strategies for coping (list at least three):

Learning to accept and deal with death is a difficult but important part of life. Examine your past experiences with and attitudes about death by answering the questions below. Circle the answer that best describes your experiences or attitudes and fill in the requested information.

1. Who died in your first personal involvement with death?
   a. Grandparent or great-grandparent
   b. Parent
   c. Brother or sister
   d. Other family member
   e. Friend or acquaintance
   f. Stranger
   g. Public figure
   h. Animal

2. To the best of your memory, at what age were you first aware of death?
   a. Under 3 years
   b. 3 to 5 years
   c. 5 to 10 years
   d. Ten years or older

3. When you were a child, how was death talked about in your family?
   a. Openly
   b. With some sense of discomfort
   c. Only when necessary and then with an attempt to exclude the children
   d. As though it were a taboo subject
   e. Never recall any discussion

4. Which of the following best describes your childhood conceptions of death?
   a. Heaven and hell concept
   b. Afterlife
   c. Death as sleep
   d. Cessation of all physical and mental activity
   e. Mysterious and unknowable
   f. Something other than the above
   g. No conception
   h. Can’t remember

5. Which of the following most influenced your present attitudes toward death?
   a. Death of someone close
   b. Specific reading
   c. Religious upbringing
   d. Introspection and meditation
   e. Ritual (e.g., funerals)
   f. TV, radio, or motion pictures
   g. Longevity of my family
   h. My health or physical condition
   i. Other (specify): _________________________

6. To what extent do you believe in a life after death?
   a. Strongly believe in it
   b. Tend to believe in it
   c. Uncertain
   d. Tend to doubt it
   e. Convinced it does not exist

7. Regardless of your belief about life after death, what is your wish about it?
   a. I strongly wish there were a life after death.
   b. I am indifferent as to whether there is a life after death.
   c. I definitely prefer that there not be a life after death.

8. How often do you think about your own death?
   a. Very frequently (at least once a day)
   b. Frequently
   c. Occasionally
   d. Rarely (no more than once a year)
   e. Very rarely or never

9. If you could choose, when would you die?
   a. In youth
   b. In the middle prime of life
   c. Just after the prime of life
   d. In old age
10. When do you believe that, in fact, you will die?
   a. In youth
   b. In the middle prime of life
   c. Just after the prime of life
   d. In old age

11. Has there been a time in your life when you wanted to die?
   a. Yes, mainly because of great physical pain
   b. Yes, mainly because of great emotional pain
   c. Yes, mainly to escape an intolerable social or interpersonal situation
   d. Yes, mainly because of great embarrassment
   e. Yes, for a reason other than above
   f. No

12. What does death mean to you?
   a. The end; the final process of life
   b. The beginning of a life after death; a transition, a new beginning
   c. A joining of the spirit with a universal cosmic consciousness
   d. A kind of endless sleep; rest and peace
   e. Termination of this life but with survival of the spirit
   f. Don’t know
   g. Other (specify): _______________________

13. What aspect of your own death is the most distasteful to you?
   a. I could no longer have any experience.
   b. I am afraid of what might happen to my body after death.
   c. I am uncertain as to what might happen to me if there is a life after death.
   d. I could no longer provide for my family.
   e. It would cause grief to my relatives and friends.
   f. All my plans and projects would come to an end.
   g. The process of dying might be painful.
   h. Other (specify): _______________________

14. In your opinion, at what age are people most afraid of death?
   a. Up to 12 years
   b. 13 to 19 years
   c. 20 to 29 years
   d. 30 to 39 years
   e. 40 to 49 years
   f. 50 to 59 years
   g. 60 to 69 years
   h. 70 years and over

15. When you think of your own death or when circumstances make you aware of your own mortality, how do you feel?
   a. Fearful
   b. Discouraged
   c. Depressed
   d. Purposeless
   e. Resolved, in relation to life
   f. Pleasure, in being alive
   g. Other (specify): _______________________

16. To what extent are you interested in having your image survive after your own death through your children, books, good works, and so on?
   a. Very interested
   b. Moderately interested
   c. Somewhat interested
   d. Not very interested
   e. Totally uninterested

17. If you had a choice, what kind of death would you prefer?
   a. Tragic, violent death
   b. Sudden but not violent death
   c. Quiet, dignified death
   d. Death in line of duty
   e. Death after a great achievement
   f. Suicide
   g. Homicide
   h. There is no “appropriate” kind
   i. Other (specify): _______________________

18. If it were possible, would you want to know the exact date on which you are going to die?
   a. Yes
   b. No
19. How important do you believe mourning and
grief ritual (such as wakes and funerals) are for
the survivors?
   a. Extremely important
   b. Somewhat important
   c. Undecided or don’t know
   d. Not very important
   e. Not important at all

20. If it were entirely up to you, how would you
like to have your body disposed of after you
have died?
   a. Burial
   b. Cremation
   c. Donation to medical school or science
   d. I am indifferent

21. What kind of a funeral would you prefer?
   a. Formal, as large as possible
   b. Small, relatives and close friends only
   c. Whatever my survivors want
   d. None

22. How do you feel about “lying in state” in an
open casket at your funeral?
   a. Approve
   b. Don’t care one way or the other
   c. Disapprove
   d. Strongly disapprove

23. Who do you feel should be the one to tell you
that you are dying?
   a. Physician
   b. Nurse
   c. Family member
   d. Close friend

24. Which aspect of yourself would you want to
take time with if you knew you would die
soon? Rate 1–10 for urgency, 1 being most
urgent.
   a. Physical
   b. Emotional
   c. Activities and plans
   d. Spiritual
   e. Relationships
   f. Playful
   g. Financial and practical
   h. Other (specify): ____________________________

25. List four things you would most like to learn,
change, or do before you die. Number 1
through 4 in priority.

26. Which rituals or activities do you feel may be
helpful for survivors and their grief process?
Mark V = Very helpful, M = Moderately
helpful, Q = Questionable, N = Not helpful,
D = Detrimental
   a. Embalming, open casket
   b. Viewing body, not embalmed
   c. Memorial service
   d. Getting rid of photos and belongings
   e. Taking trip later
   f. Remembering dead on anniversary,
holidays
   g. Talking about deceased a lot
   h. New social activities, dating
   i. Wearing black
   j. Taking a trip right away
   k. Restricting social activities
   l. Keeping belongings
   m. Moving, selling house (when not
necessary)
   n. Joining grief support groups
   o. Griev ng alone
   p. Sharing grief with children
   q. Suggested activities not mentioned:

27. Most often, how do you feel you probably
will die?
   a. Long illness
   b. Stroke or heart attack
   c. Auto crash
   d. War
   e. Violent encounter
   f. Other (specify): ____________________________
28. What is your most vivid experience with death?  
   Age: ________________
   a. Dream
   b. Experience with close person
   c. Animal
   d. Experience with stranger
   e. Story
   f. News story
   If your answer was (a), (c), or (f), briefly describe: _______________________  
   ____________________________________________

29. How is death talked about in your family at this time?  
   a. Openly
   b. Some discomfort
   c. Only when necessary
   d. Excludes children
   e. Taboo
   f. Never recall talking
   g. Excludes dying person or survivor

30. At what age did you experience the most fear of death? ________________
    Do you know what was on your mind then?
    ____________________________________________

31. If you had a terminal illness, who would you want to talk with about your “difficult” feelings?  
   (Number in preferential order):
   a. Spouse
   b. Close family member
   c. Physician
   d. Another patient
   e. Friend
   f. Nurse
   g. Therapist
   h. Clergy or spiritual friend
   i. Understanding third party

32. If a physician told you that an immediate family member was going to die, would you want them told?
   a. Yes
   b. No
   c. Depends

33. If your close friend was dying, felt depressed, and wanted to talk, how would you feel?
   a. Comfortable
   b. Embarrassed
   c. Distressed
   d. Willing
   e. Not sure
   f. Would visit less

34. When thinking of dying, I mostly fear (Rate H = High fear, M = Moderate fear, L = Low fear):
   a. Being alone
   b. Mentally disoriented
   c. Pain
   d. Disfigurement
   e. Dependence on others
   f. Loss of control over physical functions
   g. What happens at/after death
   h. Hospitalization for treatment
   i. Other (specify): _____________________________

35. When notified of a funeral—not immediate family—I usually:
   a. Decline
   b. Hate to go
   c. Happy to go
   d. Attend if at all possible
   e. Dread going

36. The cause of death I’m most afraid of is:
   a. Accident
   b. Cancer
   c. Bomb
   d. Infection
   e. Nerve disease
   f. Heart failure
   g. Kidney failure
   h. Stroke
   i. Violence
   j. Other (specify): ____________________________

Once you acknowledge the inevitability of death, you can plan for it and ease what might later be hard decisions for both your survivors and yourself. Some decisions can and should be made early so that an unexpected death is not made even more difficult for family and friends. Think about plans you can make for your own death by answering the questions below.

1. *Make a will.* You should make out a will when you reach the age of majority. It should include specific instructions about how to dispose of your property. List ten possessions in the space below and indicate whom they should go to in the event of your death.

List any money or investments you have (bank accounts, certificates of deposit, 401(k) accounts, etc.). Who would this money go to? How should it be divided?

If applicable, create some general guidelines for your executor regarding children or ongoing business investments.
2. *Decide what to do with the body.* Would you prefer your body to be embalmed or not, buried, cremated, given to medicine for research, or prepared for donating organs? What are the reasons for your choice? If you decide to donate organs, complete a Uniform Donor Card and carry it in your wallet.

3. *Plan a ceremony.* What type of ceremony would you prefer? If you choose to have a gravestone, what would you want it to say? If you have chosen cremation, what would you like done with the ashes?

4. *Choose where to die.* If death is not sudden and you have a choice, where would you prefer to spend your last days (home, hospital, hospice)? Consider the effects of your choice on you, your family, and your finances.
**Advance Medical Directives**

You can obtain a standard advance directive for your state from a local hospital, a state health department, or the not-for-profit National Hospice and Palliative Care Organization (1700 Diagonal Road, Suite 625, Alexandria, VA, 22314; 703-837-1500; www.nhpco.org). The state forms are not very specific, and you may increase the chance of a physician following your wishes if you provide more detailed instructions. The form shown below allows you to make specific choices about medical procedures under six different circumstances.

This form expresses my specific wishes regarding medical treatments in case illness prevents me from communicating them directly. My wishes apply both to the illness described and to any other situations that might develop. If a circumstance arises that my choices do not specifically address, my doctors and my agent should extrapolate from my choices below to the situation at hand. I understand that my wishes must be medically reasonable. Finally, all conclusions about my medical condition must be agreed to by my physician and appropriate consultants.

<table>
<thead>
<tr>
<th>Situation</th>
<th>Situation A</th>
<th>Situation B</th>
<th>Situation C</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>If I am in a coma or persistent vegetative state and have no known hope of recovering awareness or higher mental functions:</td>
<td>If I am in a coma and have a small but uncertain chance of regaining awareness and higher mental functioning:</td>
<td>If I am aware but have brain damage that makes me unable to recognize people, to speak meaningfully, or to live independently, and I have a terminal illness:</td>
</tr>
<tr>
<td>I want</td>
<td>I want a trial; if no clear improvement, stop treatment.</td>
<td>I want</td>
<td>I want</td>
</tr>
<tr>
<td>I do not want</td>
<td></td>
<td>I do not want</td>
<td>I do not want</td>
</tr>
</tbody>
</table>

1. **Cardiopulmonary resuscitation.**
The use of pressure on the chest, drugs, electric shocks, and artificial breathing to revive me if my heart stops.

2. **Mechanical respiration.**
Breathing by machine, through a tube in the throat.

3. **Artificial feeding.**
Giving food and water through a tube inserted either in a vein, down the nose, or through a hole in the stomach.

4. **Major surgery.**
For example, removing the gallbladder or part of the intestine.

5. **Kidney dialysis.**
Cleaning the blood by machine or by fluid passed through the abdomen.

6. **Chemotherapy.**
Drugs to fight cancer.

7. **Minor surgery.**
For example, removing part of an infected toe.

8. **Invasive diagnostic tests.**
For example, examining the stomach through a tube inserted down the throat.

9. **Transfusions of blood or blood components.**

10. **Antibiotics.**
Drugs to fight infection.

11. **Simple diagnostic tests.**
For example, blood tests or X rays.

12. **Pain medications,**
even if they dull consciousness and indirectly shorten my life.

(over)
For each of the situations at right, check the boxes that indicate your wishes regarding treatment.

<table>
<thead>
<tr>
<th>Situation D</th>
<th>Situation E</th>
<th>Situation F</th>
</tr>
</thead>
<tbody>
<tr>
<td>If I am aware but have brain damage that makes me unable to recognize people, to speak meaningfully, or to live independently, and I do not have a terminal illness:</td>
<td>If I have an incurable chronic illness that causes physical suffering or minor mental disability and will ultimately cause death, and then I develop a life-threatening but reversible illness:</td>
<td>If I am in my current state of health (describe briefly) and then develop a life-threatening but reversible disease:</td>
</tr>
<tr>
<td>I want</td>
<td>I do not want</td>
<td>I want</td>
</tr>
</tbody>
</table>

| 1. Cardiopulmonary resuscitation. The use of pressure on the chest, drugs, electric shocks, and artificial breathing to revive me if my heart stops. | I want | I do not want |
| 2. Mechanical respiration. Breathing by machine, through a tube in the throat. | | |
| 3. Artificial feeding. Giving food and water through a tube inserted either in a vein, down the nose, or through a hole in the stomach. | | |
| 4. Major surgery. For example, removing the gallbladder or part of the intestine. | I want | I do not want |
| 5. Kidney dialysis. Cleaning the blood by machine or by fluid passed through the abdomen. | | |
| 7. Minor surgery. For example, removing part of an infected toe. | I want | I do not want |
| 8. Invasive diagnostic tests. For example, examining the stomach through a tube inserted down the throat. | | |
| 9. Transfusions of blood or blood components. | | |
| 10. Antibiotics. Drugs to fight infection. | | |
| 11. Simple diagnostic tests. For example, blood tests or X rays. | | |
| 12. Pain medications, even if they dull consciousness and indirectly shorten my life. | | |

Signed: _______________________________________________________________________________________________
Signature Printed name

Address Date

Witness: _______________________________________________________________________________________________
Signature Printed name

Address Date

Witness: _______________________________________________________________________________________________
Signature Printed name

Address Date