

HIGH CHOLESTEROL ACTION PLAN

Name: _____

Medical Provider's Name: _____	Case Manager's Name: _____	Medical Social Worker's Name: _____
Phone: _____	Phone: _____	Phone: _____

THINGS TO DO EVERYDAY:

- Take my medicines as directed
- Keep a healthy weight
- Exercise regularly, such as walking for 30 minutes a day
- Eat a diet that includes 5 or more servings of vegetables and fruits daily
- Eat a diet high in fiber, low in saturated fat and cholesterol
- Bake, broil, grill, roast, steam and poach food
- Eat lean cuts of meat, such as skinless chicken and turkey or fish
- Use liquid vegetable oils high in unsaturated fat-for example; olive oils
- Read labels for fat content



I WILL CALL MY MEDICAL PROVIDER TODAY IF:

- I am having problems with my medicines
- I have tired or aching muscles

GOALS:

Date:	My Weight:	My Goal:
Date:	My Blood Pressure:	My Goal:
Date:	My LDL Cholesterol:	My Goal:
Date:	My Triglycerides:	My Goal:
Date:	My HDL Cholesterol:	My Goal:
Date:	My Total Cholesterol:	My Goal:
Date my last Lipid Profile was done:		
Date that my next Lipid Profile is due:		

THINGS TO AVOID:

- Saturated fats – especially in baked goods
- Fried foods
- Whole fat foods including ice cream, cheese and milk
- Processed meats including bacon, sausage and bologna
- Egg yolks or whole eggs
- Butter, shortening, stick margarine, coconut oil and products high in fat
- Drinks and foods with added sugars
- Tobacco products

I WILL DISCUSS WITH MY MEDICAL PROVIDER:

- Changes in diet
- Activity/Exercise
- Cholesterol lowering medicines
- Yearly flu vaccine

I WILL CALL 911 IF:

- I have chest, throat or arm tightness or pressure with or without shortness of breath, a cold sweat or nausea
- I have a sudden, severe headache with no known cause
- I have sudden weakness or numbness of my face, arm or leg
- I have sudden confusion, trouble speaking or understanding others
- I have sudden loss of balance, dizziness or difficulty seeing

NOTES:

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MY ACTION PLAN

Goal: Something I WANT to do (Example: increase physical activity, take medication, make healthier food choices, etc.)

Action: A specific activity that you are going to do in the next 1 to 2 weeks. (Example: I will walk for 30 minutes after dinner with my dog three days each week for the next two weeks.)

What you will do (the behavior):

How much you will do (time, distance, or amount of activity):

When you will do it (time of day):

How often you will do it (number of days per week):

How important is it to you that you complete the action plan you made above? (Fill in your response.)

Not at all important 1 2 3 4 5 6 7 8 9 10 Totally important

How confident are you that you will successfully complete the action plan you made above? (Fill in your response.)

Not at all confident 1 2 3 4 5 6 7 8 9 10 Totally confident

Things that might make it hard:

Ways I might overcome these problems:

Follow-up plan (phone or e-mail and date/time):