THE ADULTING VAULT

Women’s Wellness Starter Guide

Cycles, Screenings, and Being Taken Seriously by a Doctor

Everything They Forgot to Tell You

Women are told a remarkable amount about how their bodies should look and almost nothing about how they work. What a normal cycle actually is. Which screenings matter and when. Why exhaustion that everyone calls stress is sometimes iron or thyroid. What a pelvic floor does and why nobody mentions it until something goes wrong. And the one that costs the most: how to be believed in a ten-minute appointment. This is the starting map — not everything, but the things worth knowing first.

Please Read This First

This guide is general educational information, not medical advice. It is not a substitute for diagnosis, treatment, or care from a qualified clinician who knows your history. Nothing here creates a provider-patient relationship. Do not delay seeking care, or disregard advice you have been given, because of something you read here. If you think you may have a medical emergency, call 911 or go to your nearest emergency department.

CURRENCY OF THIS GUIDE

General educational information, not medical advice. It does not diagnose anything and it cannot account for your history, risk factors, or circumstances. Screening guidelines differ between professional bodies and change over time — the intervals here are a starting point for a conversation with your own clinician, not a schedule to follow independently. Anything persistent, worsening, or frightening is a reason to see a doctor rather than to consult a guide.

IF YOU NEED HELP

Where to get care

This guide is education. Finding a clinician who listens is the part it cannot do for you — these are the routes people most often do not know about.

Your insurer's member services line — **On the back of your card**

They can give you a list of in-network providers taking new patients. Faster than searching a directory that is usually out of date.

Federally Qualified Health Centers — **findahealthcenter.hrsa.gov**

Sliding-scale care regardless of insurance or ability to pay. Every state has them.

211 — **Dial 211**

Local health, prescription and transport assistance.

988 Suicide & Crisis Lifeline — **988**

Call or text 988, any time. For anyone in emotional distress — you do not have to be in crisis to use it.

National Domestic Violence Hotline — **1-800-799-7233**

Or text START to 88788. Free and confidential, whether or not anything physical has happened.

If a clinician dismisses a symptom you have raised more than once, that is a reason to seek a second opinion rather than a reason to stop asking. The guide's chapter on being taken seriously covers how to document it.

Part One: Cycle Literacy

What is normal covers a much wider range than most people are told.

The basic shape

A cycle is counted from the first day of one period to the first day of the next. It has phases driven by hormones that rise and fall in a predictable pattern, and those hormones affect considerably more than bleeding — energy, mood, sleep, appetite, body temperature, skin, and how your body responds to exercise all shift across a cycle.

Phase	Roughly when	What is happening
Menstrual	Days 1–5ish	The uterine lining sheds. Energy often lowest
Follicular	After bleeding until ovulation	Oestrogen rises. Energy and mood commonly improve
Ovulation	Around mid-cycle	An egg is released. Some people feel it as one-sided twinges
Luteal	After ovulation until the next period	Progesterone rises then falls. Where most premenstrual symptoms live

THE RANGES NOBODY GIVES YOU

CYCLE LENGTH varies widely between people and somewhat within one person. Some variation month to month is normal.

PERIOD LENGTH and flow also vary considerably. What matters more than any single number is what is normal FOR YOU, and whether that changes.

TRACKING is the point. Not to hit an ideal, but so that a change registers. A pattern you know is a pattern you can describe to a clinician.

Worth raising with a doctor

These are not emergencies and they are not things to endure quietly. They are common, frequently treatable, and routinely dismissed.

- ❑ Bleeding heavy enough to soak through hourly
- ❑ Periods lasting well over a week
- ❑ Pain that stops you working or sleeping
- ❑ Pain that painkillers do not touch

- ❑ Bleeding between periods
- ❑ Periods stopping without pregnancy
- ❑ A significant change from your own normal
- ❑ Any bleeding after menopause
- ❑ Bleeding after sex
- ❑ Cycles becoming very irregular
- ❑ Severe premenstrual mood changes
- ❑ Pain during sex

ON PERIOD PAIN SPECIFICALLY

Pain that regularly stops you functioning is not something to push through, and it is not a low pain threshold.

Conditions like endometriosis take years to diagnose on average, largely because severe pain gets normalised — by patients who were told period pain is just part of it, and by clinicians who accept that framing.

If pain is disrupting your life, say those words: "This is disrupting my life." Then ask what the next diagnostic step is.

Tracking, simply

Cycle start	Length	Flow	Pain 0–10	Other symptoms

Part Two: Screenings

Which ones, roughly when, and why the guidance disagrees.

READ THIS BEFORE THE TABLE

PROFESSIONAL BODIES GENUINELY DISAGREE on some start ages and intervals — particularly for cervical and breast screening. This is a real scientific disagreement about where benefit outweighs harm, not confusion.

Your own schedule depends on your age, family history, personal history, and risk factors. The right interval for you is a conversation, not a number from a guide.

What follows is the shape of it, so you know what to ask about. Verify current guidance with your clinician.

Screening	Broadly	Notes
Cervical	Starting in your twenties, then every 3–5 years depending on the test used	Bodies differ on whether to start at 21 or 25. HPV-based testing at longer intervals is increasingly preferred over cytology alone from around 30
Breast	Discussion in your forties; regular screening from around 40–50	The most contested. Some bodies recommend annual from 45, others biennial from 50 with an individual decision in the forties
Blood pressure	Regularly from young adulthood	Quick, free at many pharmacies, and one of the highest-value checks there is
Cholesterol and glucose	Periodically from young adulthood, more often with risk factors	A simple blood test
STI testing	With new partners, and routinely if sexually active	See Sexual Health 101 in this collection
Colorectal	From 45 for average risk	Earlier with family history
Bone density	Typically from 65, earlier with risk factors	Ask if you have had early menopause, long steroid use, or fractures
Skin	Self-check regularly; clinician check if you have risk factors	Anything new, changing, or not healing

Two things about cost

PREVENTIVE SCREENING IS USUALLY FREE

Under current federal rules most private health plans must cover recommended preventive services at no cost when you use an in-network provider. That includes many of the screenings above.

For plan years beginning after December 2025, plans must also cover the FOLLOW-UP IMAGING needed to complete a breast screening — additional mammogram views, ultrasound, or MRI — at no cost. Previously a callback could produce a substantial bill.

If you are billed for something you believed was preventive, that is worth querying rather than paying. Coding errors are common and appeals frequently succeed. See Navigating Health Insurance.

Family history changes your schedule

Ask your relatives what they have had and at what age. Breast, ovarian, colorectal and certain other cancers in close relatives can move your start date earlier or add genetic assessment. This is the single most useful piece of information you can bring to a first appointment, and most people have never asked.

Relative	Condition	Age at diagnosis

Part Three: The Things Called Stress

Three common conditions routinely missed because the symptoms sound like modern life.

Tiredness, low mood, brain fog, cold hands, hair thinning, heavy periods, breathlessness on stairs. Every one of those gets attributed to stress, poor sleep, or having a lot on. Sometimes that is right. Sometimes it is a blood test away from an answer.

Iron deficiency

Common in menstruating people, particularly with heavy periods, and it develops slowly enough that you adapt to feeling worse. You can be iron deficient without being anaemic, and standard blood counts do not always catch it — ferritin is the test that shows stored iron.

- Exhaustion that rest does not fix
- Breathlessness on ordinary exertion
- Cold hands and feet
- Hair shedding more than usual
- Brittle nails, or a craving for ice or non-food substances
- Difficulty concentrating

If you have heavy periods and persistent fatigue, ask specifically about ferritin as well as a full blood count. Ask for your actual numbers rather than accepting "normal" — the range is wide and the bottom of it is not where most people feel well.

Thyroid

Thyroid conditions are substantially more common in women and the symptoms are almost entirely non-specific — which is exactly why they get missed.

UNDERACTIVE — FATIGUE, WEIGHT GAIN, COLD INTOLERANCE, DRY SKIN, CONSTIPATION, LOW MOOD, HEAVY PERIODS, HAIR LOSS	OVERACTIVE — ANXIETY, WEIGHT LOSS, HEAT INTOLERANCE, PALPITATIONS, TREMOR, LOOSE STOOLS, LIGHT OR ABSENT PERIODS

Sleep

Persistent poor sleep is treated as a lifestyle failing and it is frequently a medical one. Sleep apnoea in particular is under-diagnosed in women because it presents differently — more fatigue and insomnia, less of the classic loud snoring picture.

- Waking unrefreshed no matter the hours
- Falling asleep unintentionally during the day
- Being told you stop breathing or gasp
- Morning headaches

> **WHAT TO ACTUALLY ASK FOR**
>
> "I have been tired for months and it is not improving with rest. Could we check my ferritin, full blood count, thyroid function, and vitamin D?"
>
> That single sentence names symptoms, states persistence, and requests specific tests. It is far harder to wave away than "I have been feeling tired."

Part Four: Pelvic Floor

A muscle group nobody mentions until something goes wrong.

The pelvic floor is a sling of muscle supporting the bladder, bowel and uterus. Like any muscle it can be weak, and — less commonly discussed — it can also be too tight. Both cause problems, and the treatments are opposite, which is why guessing is unhelpful.

Signs it needs attention

- ❑ Leaking when you cough, laugh, sneeze or jump
- ❑ Sudden urgency, or going very frequently
- ❑ A feeling of heaviness or dragging
- ❑ Difficulty emptying fully
- ❑ Pain during sex
- ❑ Difficulty inserting a tampon
- ❑ Lower back or hip pain with no clear cause
- ❑ Constipation that will not resolve

LEAKING IS COMMON AND IT IS NOT SOMETHING YOU HAVE TO ACCEPT

It is extremely common after childbirth and around menopause, and commonly treatable — frequently without surgery.

A pelvic floor physiotherapist is a specialist role and referral is available in many places. This is the single most under-used referral in women's health.

Doing more Kegels is not universal advice. If your pelvic floor is too TIGHT, strengthening exercises make symptoms worse. That is why an assessment matters more than a YouTube routine.

If you are pregnant or postpartum

- Pelvic floor work during pregnancy is protective, not just rehabilitative
- Ask about assessment at your postnatal check specifically — it is not always offered
- Symptoms months or years after birth are still worth treating. There is no expiry

Part Five: Being Believed

The most useful skill in this guide.

Women report having symptoms attributed to stress, anxiety, or weight more often than men do, and wait longer for diagnosis across a range of conditions. Knowing that is not a reason for despair — it is a reason to walk in prepared, because preparation measurably changes how a ten-minute appointment goes.

Before the appointment

1. WRITE IT DOWN. Symptom, when it started, how often, what makes it better or worse, and what it stops you doing. Bring the paper.
2. LEAD WITH IMPACT. "This stops me sleeping four nights a week" is harder to dismiss than "I have been getting headaches."
3. PICK YOUR TOP TWO. A list of nine gets triaged for you, and rarely in the order you wanted.
4. BRING FAMILY HISTORY, and any test results you already have.
5. WRITE YOUR QUESTIONS DOWN and leave space for the answers.

The four sentences that change appointments

> **USE THESE**
>
> "This is affecting my daily life." — states impact, not just symptom.
>
> "What else could this be?" — opens the differential rather than accepting the first answer.
>
> "What would need to be true for us to investigate further?" — turns a no into a threshold.
>
> "Could you note in my chart that I raised this and that we decided not to investigate?" — entirely reasonable, changes the conversation immediately, and creates a record.

If you are dismissed

- Ask for the reasoning. "What makes you confident it is stress rather than something else?"
- Ask what would change their mind, and what should bring you back
- Ask for the specific test by name. A named request is harder to decline than a vague worry

- Get a second opinion. This is normal, it is not disloyal, and you do not need permission
- Bring someone with you. It should not make a difference and it demonstrably sometimes does

Weight and the appointment

If you have had a symptom attributed to weight without examination, you are allowed to say: "I would like this investigated on its own terms. If weight is a factor we can discuss that separately." Symptoms deserve investigation regardless, and unexamined attribution is how conditions get missed.

Part Six: Your Care Team

Who does what, and what to have in place.

Who	For
Primary care clinician	The hub. Routine care, referrals, and someone who knows your history over time
Gynaecologist	Cervical screening, contraception, cycle problems, menopause, pelvic pain
Pelvic floor physiotherapist	Leaking, prolapse, pain with sex, postnatal recovery
Dentist	Twice yearly, and genuinely connected to wider health
Optometrist	Eyes, and an early window on blood pressure and diabetes
Dermatologist	Skin checks if you have risk factors
Mental health clinician	As needed. See Therapy 101 in this collection

The one worth prioritising

A primary care clinician who knows you is worth more than any single specialist. Continuity is what allows someone to notice that this is different from your baseline — which is the thing no one-off appointment can do.

Your records

- ❑ Know how to access your own results online
- ❑ Ask for copies of anything significant
- ❑ Keep a running note of diagnoses, medications, and surgeries
- ❑ Record your family history once, properly

Role	Name	Phone	Last seen

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Closing

Most of this comes down to two habits. Know your own normal well enough that a change registers. And describe symptoms by their impact rather than their severity, because impact is what gets investigated.

And when something has been dismissed and you still think something is wrong — you are allowed to ask again, ask someone else, and keep asking. Being persistent about your own body is not being difficult.

THE SIX THAT MATTER MOST

Track your cycle so a change registers. Not to match an ideal.

Pain that stops you functioning is not normal and not a low pain threshold.

Guideline bodies disagree on screening ages. Your schedule is a conversation, not a number.

Persistent exhaustion: ask specifically for ferritin, full blood count, and thyroid function.

Leaking is common and treatable. Ask about pelvic floor physiotherapy.

"Could you note in my chart that I raised this?" changes an appointment immediately.