CLINICAL SCREENING FORM

WISEWOMAN

☐Initial Visit ☐Follow-Up Screening (Post-HBSS) ☐Re-Screening (12-18mos post)

AGENCY OR SITE	CHART #	DATE	DOB

LAST NAME	FIRST NAME	RACE	ETHNICITY
		☐ White ☐ Black ☐ Asian ☐ Amer Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander	☐ Hispanic ☐ Non-Hispanic
ADDRESS	**CITY**	**STATE**	**ZIP**
PHONE NUMBER _____-_____-_____	**BEST TIME TO CALL** ☐ Morning ☐ Afternoon ☐ Evening ☐ Anytime	**PRIMARY LANGUAGE** ☐ English ☐ Spanish ☐ Creole ☐ Other _____	**ENROLLED IN FBCCEDP?** ☐ Yes ☐ No

PATIENT INSTRUCTIONS: Please fill in each part below.

1. What is the highest level of education you have completed?
   - ☐ < 9th grade
   - ☐ High school graduate or equivalent
   - ☐ Some college or higher
   - ☐ Some high school
   - ☐ Don't know/not sure

MEASUREMENTS

2. WEIGHT (LBS):	3. HEIGHT:	4. WAIST CIRCUMFERENCE (IN):
_____	___' ___"	_____

5. BLOOD PRESSURE _____ /_____

PATIENT HEALTH HISTORY

6. Have you had any of the following?
   - a. ☐Stroke/transient ischemic attack (TIA)
   - b. ☐Heart Attack
   - c. ☐Coronary Heart Disease
   - d. ☐ Heart Failure
   - e. ☐ Vascular Disease (peripheral arterial disease)
   - f. ☐ Congenital Heart Disease

7. Do you have any of the following conditions?
8. Hypertension ☐Yes ☐No ☐Not sure
9. High cholesterol ☐Yes ☐No ☐Not sure
10. Diabetes (Type 1 or Type 2) ☐Yes ☐No ☐Not sure

11. Have you been prescribed medication for the following:
    - a. Lower blood pressure? ☐Yes ☐No ☐Not sure ☐N/A
    - b. Lower cholesterol? ☐Yes ☐No ☐Not sure ☐N/A
      If yes, please select the correct option: ☐Statin ☐Other _____
    - c. Blood Sugar? ☐Yes ☐No ☐Not sure ☐N/A

12. Are you taking aspirin daily to help prevent a heart attack or stroke?
    ☐Yes ☐No ☐Not sure

13. a. Do you measure your blood pressure at home or using other calibrated sources? ☐Yes ☐No
    b. If yes, how often do you measure your blood pressure at home or using other calibrated sources?
    ☐Multiple times per day ☐Daily ☐A few times per week ☐Weekly ☐Monthly ☐Not sure

14. Do you regularly share blood pressure readings with a health care provider for feedback? ☐Yes ☐No ☐Not sure

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15. During the past 7 days, how many days did you take prescribed medication for the following conditions?
High blood pressure _____ days High cholesterol _____ days High blood sugar _____ days

LIFESTYLE

16. In the past 7 days, how often have you had a drink of alcohol? _____
17. How many alcoholic drinks, on average, do you consume during a day when you drink? _____
18. Do you smoke? Include cigarettes, pipes, or cigars (smoked tobacco in any form) ☐Yes ☐No
19. How many minutes of physical activity (exercise) do you get in a week? _____
20. How often do you consume fast food? ☐Never ☐ 1-2 d/wk ☐ 3-4d/wk ☐5-6 d/wk ☐Every day
21. How many cups of fruits and vegetables do you eat in an average day? _____
22. Do you eat fish at least two times a week? ☐Yes ☐No
23. Thinking about all the servings of grain products you eat in a typical day, how many are whole grains?
☐ Less than half ☐Half ☐More than half
24. Do you drink less than 36 ounces (450 calories) of sugar sweetened beverage weekly? ☐Yes ☐No
25. Are you currently watching or reducing your sodium or salt intake? ☐Yes ☐No
26. How many cups of water do you drink daily? ☐None ☐ 1-2 cups ☐ 3-4cups ☐5-6cups ☐7 or more

27. Over the past 2 weeks, how often have you been bothered by any of the following problems:	Not at all	Several Days	More than half the days	Nearly Every Day
a. Little interest or pleasure in doing things	☐	☐	☐	☐
b. Feeling down, depressed or hopeless	☐	☐	☐	☐

ALERT VALUE FOLLOW-UP *(clinic use)*

Schedule medical follow-up within seven (7) days of screening for medical evaluation and treatment. Document status of workup using codes below.

ALERT BLOOD PRESSURE	ALERT BLOOD GLUCOSE
Alert Blood Pressure SBP > 180 or DBP > 110mmHG Evaluation Visit Date: ___/___/___ *Status of Work-Up: _____ (Number from below)	Alert Blood Glucose SBP ≤50 or ≥250 mg/dl Evaluation Visit Date: ___/___/___ *Status of Work-Up: _____ (Number from below)

Is a medical follow-up for blood pressure reading necessary?
☐Medically necessary ☐Not medically needed ☐Medically necessary-Client Refused work-up

Alert Value Notes/Comments:

OTHER

Date Risk Counseling Completed: ____/____/____
Client Priority Area(s): ☐ None ☐Healthy Eating ☐Physical Activity ☐Smoking Cessation
☐ Self-Measured Blood Pressure Monitoring ☐Medication Therapy Management Support ☐Diabetes Prevention
☐ Health Coaching
☐ **Physical Activity Clearance Denied.** Client not cleared for physical activity until further evaluation

HBSS Referred To: ☐Health Coaching ☐Diabetes Prevention Program ☐Weight Watchers ☐Tobacco Quitline
☐Community Based Tobacco Cessation Resource ☐Self-Monitored Blood Pressure Management w/ Support ☐Other _____
Referral Date: ___/___/___

Number of Lifestyle Program (LSP)/Health Coaching (HC) Sessions Received: _____

Tobacco Cessation Activity Completed:
☐Yes – Completed tobacco cessation activity ☐No –Discontinued from tobacco cessation activity

PATIENT NAME/ID: _____

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☐**No –Partially completed tobacco cessation activity**	☐**No – Could not reach to conduct tobacco cessation activity**
Comments:	