**Date**: \_\_\_\_\_\_\_\_\_\_ **Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DOB**: \_\_\_\_\_\_\_\_\_\_\_\_ **Provider**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Height** (in 0’0”) \_\_\_\_\_\_\_\_\_\_\_\_\_ **Weight** (in lbs.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Waist circumference** \_\_\_\_\_\_\_\_\_\_\_\_\_

*If the answer to #1 in any of these sections is “No”/“Don’t Know”/“Don’t want to answer”, skip to the next section.*

|  |  |  |
| --- | --- | --- |
| **Blood Pressure** | 1. Do you have hypertension (high blood pressure)?   Yes  No  Don’t know  Don’t want to answer | |
| 1. Was medication prescribed to lower your blood pressure?  Yes  No  Don’t know  Don’t want to answer | |
| 1. During the past 7 days, on how many days did you take prescribed medication to lower your blood pressure? \_\_\_\_\_\_\_\_\_\_\_\_ Number of days  None  Don’t know  Don’t want to answer | |
| 1. Do you measure your blood pressure at home or use other calibrated sources (e.g. at a pharmacy)? | |
| Was never told to measure BP  Don’t know how to measure BP | Don’t have equipment to measure BP  Don’t know  Don’t want to answer |
| 1. How often do you measure your blood pressure?  Multiple times per day  Daily  A few times per week  Weekly  Monthly  Never  Don’t Know  Don’t want to answer | |
| 1. Do you regularly share BP readings with a health care provider?   Yes  No  Don’t know  Don’t want to answer | |
| **Cholesterol** | 1. Do you have high cholesterol?  Yes  No  Don’t know  Don’t want to answer | |
| 1. Was medication (Statin) prescribed to lower your cholesterol?   Yes  No  Don’t know  Don’t want to answer | |
| 1. Was medication (other than Statin) prescribed to lower your cholesterol?   Yes  No  Don’t know  Don’t want to answer | |
| 1. During the past 7 days (including today), on how many days did you take prescribed medication to lower your cholesterol?   \_\_\_\_\_\_\_\_\_\_\_\_ Number of days  None  Don’t know  Don’t want to answer | |
| **Diabetes** | 1. Do you have diabetes? (Type 1 or 2?)  Yes  No  Don’t know  Don’t want to answer | |
| 1. Was medication prescribed to lower your blood sugar (for diabetes)?   Yes  No  Don’t know  Don’t want to answer | |
| 1. During the past 7 days, on how many days did you take prescribed medication to lower your blood sugar (for diabetes)?   \_\_\_\_\_\_\_\_\_\_\_\_ Number of days  None  Don’t know  Don’t want to answer | |
| **Cardiovascular** | 1. Have you been diagnosed by a health care provider as having any of these conditions?  * **Stroke/TIA**  Yes  No  Don’t know  Don’t want to answer * **Heart attack**  Yes  No  Don’t know  Don’t want to answer * **Coronary heart disease**  Yes  No  Don’t know  Don’t want to answer * **Heart failure**  Yes  No  Don’t know  Don’t want to answer * **Vascular disease (peripheral arterial disease)**   Yes  No  Don’t know  Don’t want to answer   * **Congenital heart disease or defects**   Yes  No  Don’t know  Don’t want to answer | |
| 1. Are you taking aspirin daily to help prevent a heart attack or stroke?   Yes  No  Don’t know  Don’t want to answer | |

**Lifestyle Questions**

|  |  |  |
| --- | --- | --- |
| 1. How many cups of fruits and vegetables do you eat in an average day?   \_\_\_\_\_\_\_\_\_ Number of cups  None  Don’t know  Don’t want to answer | | |
| 1. Do you eat 2 servings or more of fish weekly?  Yes  No  Don’t know  Don’t want to answer | | |
| 1. Of the grain products you eat in a typical day, how many are whole grain?   Less than half  About half  More than half  Don’t want to answer | | |
| 1. Do you drink less than 36 ounces (450 calories) of beverages with added sugars weekly?   Yes  No  Don’t know  Don’t want to answer | | |
| 1. Are you currently watching or reducing your sodium or salt intake?   Yes  No  Don’t know  Don’t want to answer | | |
| 1. In the past 7 days, how often did you have a drink containing alcohol?   \_\_\_\_\_\_\_\_\_\_\_\_ Number of times  None  Don’t know  Don’t want to answer | | |
| 1. How many alcoholic drinks, on average, do you consume during a day you drink?   \_\_\_\_\_\_\_\_\_\_\_\_ Number of drinks  None  Don’t know  Don’t want to answer | | |
| 1. How many minutes of physical activity/exercise do you get in a week?   \_\_\_\_\_\_\_\_\_\_\_\_ Number of minutes  None  Don’t know  Don’t want to answer | | |
| 1. Do you smoke (include cigarettes, pipes, cigars, vaping, or any smoked tobacco)?  Current smoker   Quit 1-12 months ago  Quit more than 12 months ago  Never smoked  Don’t want to answer | | |
| 1. Over the past 2 weeks, how often have you been bothered by little interest or pleasure in doing things?   Not at all  Several days  More than half  Nearly every day  Don’t want to answer | | |
| 1. Over the past 2 weeks, how often have you been bothered by feeling down, depressed, or hopeless?   Not at all  Several days  More than half  Nearly every day  Don’t want to answer | | |
| **Blood Pressure:** BP reading: \_\_\_\_\_\_\_ /\_\_\_\_\_\_\_ mm Hg 2nd BP reading (optional): \_\_\_\_\_\_\_ / \_\_\_\_\_\_\_ mm Hg  ALERT/BP Disease Level Follow-up  Not medically needed  Medically necessary: Follow up date \_\_\_\_\_\_\_\_\_\_\_   Medically necessary, but declined  Client refused workup | | |
| **Cholesterol and Lipids - Fasting  Yes  No**  Total Cholesterol: \_\_\_\_\_\_ mg/dl  HDL Cholesterol: \_\_\_\_\_\_mg/dl  LDL Cholesterol: \_\_\_\_\_\_\_\_\_\_\_\_\_ mg/dl  Triglycerides: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_mg/dl | **Glucose/A1C Testing – Fasting  Yes  No**  HgA1C for diabetes monitoring  HgA1C by POC: \_\_\_\_\_\_\_%  Diabetes Screening  HgA1C by venipuncture: \_\_\_\_\_\_\_%  Fasting Glucose: \_\_\_\_\_\_\_\_\_\_mg/dl | **If no test,** check reason:  Inadequate sample  Client refused  No measurement recorded |
| **Labs and Follow-up**  Lab used: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date sent to lab: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Labs reviewed with patient?**  Yes  No  **Sent in writing?**  Yes  No  Date patient informed of lab results (if not avail same day): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| **Risk Reduction**  **Risk Reduction Counseling completed?**  Yes Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  No  **Tobacco Cessation** If referred for smoking cessation, which resource? Check all that apply.  Tobacco Quit Line  Community-based tobacco program  Other tobacco cessation resource (e.g. 2Morrow App)  **Outcome of tobacco cessation referral**, if applicable:  Completed  Partially completed  Not completed/declined  **Referral Program**:  Blood pressure Self-Monitoring  Health Coaching  BP Self-Monitoring w/ Clinical Support  Big 4 Health Coaching  Diabetes Prevention Program  Lose to Win YMCA | | |