MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES

WISEWOMAN Assessment Form

LAST NAME	FIRST NAME	MIDDLE INITIAL	DOB (MM/DD/YYYY)	DATE OF VISIT (MM/DD/YYYY)

A. Health History (Check ☒ as appropriate)

1. Do you have high cholesterol? ☐ Yes ☐ No ☐ Don't Know/Not Sure

   If you answered No, skip to question 2.

   a. Do you take medication to lower your cholesterol? ☐ Yes ☐ No ☐ Don't Know/Not Sure

      i. Is the medication a statin? ☐ Yes ☐ No ☐ Don't Know/Not Sure

   b. If yes, during the past seven (7) days, including today, how many days did you take prescribed medication to lower your cholesterol?
   _____Number of Days
   ☐ None, I could not obtain medication
   ☐ Don't Know/Not Sure

2. Do you have hypertension (high blood pressure)? ☐ Yes ☐ No ☐ Don't Know/Not Sure

   If you answered No, skip to question 3.

   a. Do you take medication to lower your blood pressure? ☐ Yes ☐ No ☐ Don't Know/Not Sure

   b. If yes, during the past seven (7) days, how many days did you take prescribed medication (including diuretics/water pills) to lower your blood pressure?
   _____Number of Days
   ☐ None, I could not obtain medication
   ☐ Don't Know/Not Sure

   c. Do you measure your blood pressure at home or use another blood pressure machine located in the community? ☐ Yes ☐ No
   ***If no**, check reason:*
   ☐ I was never told to measure my blood pressure
   ☐ I don't know how to measure my blood pressure
   ☐ I don't have equipment to measure my blood pressure

   ***If yes**:*

      i. How often do you measure your blood pressure at home or use another blood pressure machine located in the community?
      ☐ Multiple times per day
      ☐ Daily ☐ A few times per week
      ☐ Weekly ☐ Monthly
      ☐ Other (don't measure)
      ☐ Don't Know/Not Sure

      ii. Do you regularly share blood pressure readings with your health care provider for feedback? ☐ Yes ☐ No ☐ Don't Know/Not Sure

3. Do you have diabetes (Either Type 1 or Type 2)? ☐ Yes ☐ No ☐ Don't Know/Not Sure

   If you answered No, skip to question 4.

   a. Do you take medication to lower your blood sugar (for diabetes)? ☐ Yes ☐ No ☐ Don't Know/Not Sure

   b. If yes, during the past seven (7) days, how many days did you take prescribed medication to lower blood sugar (for diabetes)?
   _____ Number of days
   ☐ None. I could not obtain medication
   ☐ Don't Know/Not Sure

4. Have you been diagnosed by a healthcare provider as having any of these conditions:
   a. Stroke/transient ischemic attack (TIA) ☐ Yes ☐ No ☐ Don't Know/Not Sure
   b. Heart attack ☐ Yes ☐ No ☐ Don't Know/Not Sure
   c. Coronary heart disease ☐ Yes ☐ No ☐ Don't Know/Not Sure
   d. Heart failure ☐ Yes ☐ No ☐ Don't Know/Not Sure
   e. Vascular disease (peripheral arterial disease) ☐ Yes ☐ No ☐ Don't Know/Not Sure
   f. Congenital heart disease and defects? ☐ Yes ☐ No ☐ Don't Know/Not Sure

B. Health History (Check ☒ as appropriate)

1. Are you taking aspirin daily to prevent heart attack or stroke? ☐ Yes ☐ No
2. How many cups of fruit and vegetables do you eat in an average day? ____ Cups ☐ None
3. Do you eat two (2) servings or more of fish weekly? ☐ Yes ☐ No
4. How many servings of grain products do you eat in a typical day? ☐ ½ serving or less ☐ ½ serving ☐ ½ serving or more ☐ None
5. How many servings are whole grains (oatmeal, cereal, bread, etc.)? ☐ ½ serving or less ☐ ½ serving ☐ ½ serving or more ☐ None
6. Do you drink less than 36 ounces (450 calories) of beverages with added sugars weekly? ☐ Yes ☐ No
7. Are you currently watching or reducing your sodium or salt intake? ☐ Yes ☐ No
8. Physical Activity
   a. How many minutes of physical activity (exercise) do you get in a week? ____ Number of minutes ☐ None
9. Alcohol
   a. In the past seven (7) days, how often did you have a drink containing alcohol? ____ Number of days ☐ Don't Know/ Not Sure
   b. How many alcoholic drinks, on average, do you consume during a day you drink? ____ Number of drinks containing alcohol
10. Overall Wellness
    Over the past two (2) weeks, how often have you been bothered by any of the following problems?
    a. Have little interest or pleasure in doing things? ☐ Not at all ☐ Several days ☐ More than half of the month ☐ Nearly every day
    b. Feeling depressed or hopeless? ☐ Not at all ☐ Several days ☐ More than half of the month ☐ Nearly every day
11. Tobacco Products
    a. Do you smoke (including cigarettes, pipes, cigars, or e-cigarettes)? ☐ Current smoker ☐ Quit (1-12 months ago) ☐ Quit (More than 12 months ago) ☐ Never Smoked
    b. Did you complete a tobacco cessation activity? ☐ Yes ☐ No ☐ Discontinued activity ☐ Not sure

C. Readiness to Change Health Habits (Check ☒ as appropriate)

Check the one box by each of the following three statements that best describes your behavior today.	I have little or no intention to change my behavior in the foreseeable future.	I am thinking about making a change in my behavior.	I am ready to plan how I will make a change in my behavior.	I am in the process of trying to make a change in my behavior.	I am trying to maintain a change I have made in my behavior.
1. Eat more fruits and vegetables	☐	☐	☐	☐	☐
2. Quit smoking/utilizing tobacco	☐	☐	☐	☐	☐ (or never smoked)
3. Increase physical activity	☐	☐	☐	☐	☐