



WISEWOMAN Follow-Up Rescreen

Completed at 4th Health Coaching Session



LAST NAME	FIRST NAME	MIDDLE INITIAL	DOB (MM/DD/YYYY)	DATE OF VISIT (MM/DD/YYYY)
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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?
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 defects? Yes No Don't Know/Not Sure

5. Are you taking an aspirin daily to prevent heart attack or stroke? Yes No

B. Health History (Check as appropriate)

1. How many cups of fruit and vegetables do you eat in an average day? Cups None
2. Do you eat two (2) servings or more of fish weekly? Yes No
3. How many servings of grain products do you eat in a typical day? ½ serving or less ½ serving
 ½ serving or more None
4. How many servings are whole grains (oatmeal, cereal, bread, etc.)? ½ serving or less ½ serving
 ½ serving or more None
5. Do you drink less than 36 ounces (450 calories) of beverages with added sugars weekly? Yes No
6. Are you currently watching or reducing your sodium or salt intake? Yes No
7. Physical Activity
a. How many minutes of physical activity (exercise) do you get in a week? Number of minutes None
8. Alcohol
a. In the past seven (7) days, how often did you have a drink containing alcohol? Number of days Don't Known/ Not Sure
b. How many alcoholic drinks, on average, do you consume during a day you drink? Number of drinks containing alcohol
9. 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
10. 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. Tobacco cessation activity completed. Yes No
 Discontinued activity
 Not sure

C. Survey of Services Rendered

Has the WISEWOMAN Program improved the quality of your life?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Are you satisfied with the services offered by the WISEWOMAN Program?	<input type="checkbox"/> YES	<input type="checkbox"/> NO

D. Clinical Measurements

TO BE COMPLETED BY CLINICIAN

BMI: _____	Height: _____	Weight: _____ lbs.	Waist circumference: _____ Hip circumference: _____ Ratio: _____
BP 1 st _____/_____	BP 2 nd _____/_____	Average BP _____/_____	Hypertension Follow-up (>130/80) <input type="checkbox"/> Medical Follow-up <input type="checkbox"/> Health Coaching <input type="checkbox"/> SMBP <input type="checkbox"/> Client Refused
<input type="checkbox"/> Labs Not Done	Fasting (9-12 hours) <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> BMP <input type="checkbox"/> CMP	
<input type="checkbox"/> A1C	LIPID PANEL (Fasting only) <input type="checkbox"/> Total Cholesterol	<input type="checkbox"/> HDL	<input type="checkbox"/> LDL <input type="checkbox"/> Triglycerides
RISK REDUCTION COUNSELING:	<input type="checkbox"/> Healthy Eating <input type="checkbox"/> Physical Activity <input type="checkbox"/> Smoking Cessation <input type="checkbox"/> BP Management	LSP Referral:	<input type="checkbox"/> ESBA <input type="checkbox"/> DPP <input type="checkbox"/> TOPS <input type="checkbox"/> Tobacco Quitline <input type="checkbox"/> Weight Watchers <input type="checkbox"/> Health Coaching <input type="checkbox"/> Other HBSS

COMMENTS: